DOCUMENT RESUME

ED 297 056 UD 026 282

AUTHOR	Munoz, Eric; And Others
TITLE	A Profile of Puerto Rican Health in the United States: Data from the Hispanic Health and Nutrition Examination Survey 1982-84.
INSTITUTION	Health Services Research, Arlington, TX.; Long Island Jewish Medical Center, NY.
PUB DATE	Mar 88
NOTE	89p.; This document was sponsored in part by the Association of Puerto Ricans in Science and Engineering.
AVAILABLE FROM	Long Island Jewish Medical Center, Department of Surgery, 270-05 76th Avenue, New Hyde Park, NY 11042 ($12.00).
PUB TYPE	Statistical Data (110) -- Reports - Research/Technical (143)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Contraception; Dental Health; Diseases; Females; Financial Problems; *Health Needs; Males; *Medical Evaluation; *Medical Services; Physical Examinations; *Physical Health; *Puerto Ricans; Statistical Surveys; Urban Population
IDENTIFIERS	Health and Nutrition Examination Survey; *Health Attitudes; *Health Behavior

ABSTRACT

The health conditions and health status of Hispanic Americans will assume increased importance as their population increases. The goal of this book of charts is to present data from the Hispanic Health and Nutrition Examination Survey (HHANES) on Puerto Ricans. The Puerto Rican HHANES sampling procedure is a multi-stage probability sample of civilian non-institutionalized Puerto Ricans in New York City. From July 1982 through November 1983, 2,834 persons were interviewed and examined. Data were gathered on sociodemographic background, health status, reproduction and fertility factors, health care utilization, and financial issues. Findings include the following: (1) Puerto Ricans represent the second largest Hispanic American subgroup; (2) they have a median age of 23 years; (3) they have limited education, with 59% having been graduated from high school; (4) the New York City area has the largest concentration of Puerto Ricans; (5) 48% have an income below the poverty level; (6) most families have four or fewer members; (7) females reported higher rates of health problems than males; (8) non-use of health care was related to cost and long periods of waiting; and (9) SES had considerable influence upon whether health care was received when needed. Extensive charts of statistical data, a list of references, and a subject index are included. (FMW)

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A Profile of Puerto Rican Health in the United States: Data from the Hispanic Health and Nutrition Examination Survey 1982–84

ED297056

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March, 1988

Table of Contents

Page

Foreword 5

Table of Charts 7

Chapter 1

Introduction 11

Previous Studies of Hispanic Health 11

HHANES Survey 12

Goal and Objectives 13

Design of HHANES Sample 13

Chapter 2

Sociodemographic Context 17

Chapter 3

Health Status 27

Chapter 4

Reproduction and Fertility Factors 71

Chapter 5

Health Care Utilization 75

Chapter 6

Financial Issues 87

Subject Index 91

Foreword

"A Profile of Puerto Rican Health in the United States: Data from the Hispanic Health and Nutrition Examination Survey 1982–84" is intended to give a graphic overview of mainland Puerto Rican American health concerns—to highlight some key facts about this population group, their health status and needs, their utilization of health services and participation in health programs, and their involvement in health resources. The omission of certain critical analysis from each chart is deliberate. It is hoped that researchers interested in this data will find this chart book an important resource in their work. Further analysis of this group of Americans will be required in the future.

Eric Muñoz, M.D., M.B.A., Pedro J. Lecca, Ph.D.,
and Jonathan D. Goldstein, M.P.A.

This book deals with the health of Hispanics—Puerto Ricans in particular, and will be presented at a Health Conference for the New York State Legislature in Albany. It is the most comprehensive work to date on the status of Puerto Rican health; more work needs to be done regarding the health issues for this population. We hope that this analysis will serve as a model for other public policy analyses. It is significant to note that Hispanics will be the largest minority group in the United States by the year 2,000. They are growing at a much more rapid rate than any other minority group, and data suggests that Hispanics have more severe health problems than the U.S. population in general. Analyses such as presented in this book will help focus on Hispanic health care issues for the American people in the future.

Robert K. Match, M.D., President,
Long Island Jewish Medical Center

Table of Charts

1. Introduction **Page**

1.1 Number of Completed Interviews by State of Residence and Language of Interview 14

2. Sociodemographic Context

2.1 Population Pyramid 18
2.2 Educational Attainment in Years 19
2.3 Labor-force Status by Sex 20
2.4 Family Income and Cumulative Family Income 21
2.5 Distribution and Cumulative Distribution of Households by Poverty Index 22
2.6 Family Size and Cumulative Family Size 23
2.7 Household Size and Cumulative Household Size 24
2.8 Place of Birth and Ancestry 25

3. Health Status

3.1 Self-assessment and Physician's Assessment of General Health Status 28
3.2 Age-Sex Specific Rates for "Excellent" Health Status 29
3.3 Relationship of General Health Status to Sex, Ancestry, and Place of Birth 30
3.4 Relationship of General Health Status to Poverty Level and Health Insurance Coverage 31
3.5 Physician's Assessment of Weight Status 32
3.6 Self-assessment of Condition of Teeth and Gums 33
3.7 Age-Sex Mean Diastolic and Systolic Blood Pressure Levels of Male and Female Respondents 34
3.8 Age-Sex Mean Systolic Blood Pressure Levels for Male and Female Respondents 35
3.9 Previously Undiagnosed Hypertension, Control of Known Hypertensives 36
3.10 Age-Sex Specific Rates for Diagnosis of Hypertension . 37
3.11 Salt Reduction, Use of Medication, and Weight Control Practices by Diabetics 38
3.12 Age-Sex Specific Rates for Diabetics 39
3.13 Insulin Injections, Use of Medication, and Dietary Practices by Diabetics 40
3.14 Age-Sex Specific Rates for Diagnosis of Tuberculosis . 41
3.15 Age-Sex Specific Rates for Anemia 42
3.16 Age-Sex Specific Rates for Chest Pain 43
3.17 Responses to Chest Pain 44
3.18 Age-Sex Specific Rates for Diagnosis of Emphysema . . 45
3.19 Age-Sex Specific Rates for Diagnosis of Bronchitis . . . 46
3.20 Age-Sex Specific Rates for Diagnosis of Rheumatic Heart Disease 47
3.21 Age-Sex Specific Rates for Diagnosis of Rheumatic Fever 48
3.22 Age-Sex Specific Rates for Diagnosis of Heart Murmur 49

Table of Charts

Continued

3.23 Age-Sex Specific Rates for Diagnosis of Heart Failure 50
3.24 Age-Sex Specific Rates for Diagnosis of Heart Attack 51
3.25 Age-Sex Specific Rates for Diagnosis of Kidney Problems 52
3.26 Age-Sex Specific Rates for Diagnosis of Cirrhosis 53
3.27 Age-Sex Specific Rates for Diagnosis of Hepatitis 54
3.28 Age-Sex Specific Rates for Diagnosis of Yellow Jaundice 55
3.29 Age-Sex Specific Rates for Diagnosis of Stroke 56
3.30 Age-Sex Specific Rates for Diagnosis of Glaucoma . . . 57
3.31 Age-Sex Specific Rates for Diagnosis of Cataracts 58
3.32 Age-Sex Specific Rates for Diagnosis of Strabismus . . . 59
3.33 Age-Sex Specific Rates for Diagnosis of Eye Injury 60
3.34 Age-Sex Specific Rates for Diagnosis of Goiter 61
3.35 Age-Sex Specific Rates for Diagnosis of Thyroid Disease 62
3.36 Age-Sex Specific Rates for History of Tobacco Use 63
3.37 Age and Cumulative Age at Which Respondent Started Smoking 64
3.38 Age-Sex Specific Rates for Current Tobacco Use 65
3.39 Aspects of Tobacco Use 66
3.40 Age-Sex Specific Mean Serum Cholesterol Levels 67
3.41 Age-Sex Specific Rates for Vision Impairment 68
3.42 Age-Sex Specific Rates for Hearing Impairment 69

4. Reproduction and Fertility Factors

4.1 Age and Cumulative Age at Menarche 72
4.2 Aspects of Fertility 73
4.3 Time Since Last Pap Smear and Breast Examination . . 74

5. Health Care Utilization

5.1 Health Care Utilization I 76
5.2 Health Care Utilization II 77
5.3 Health Care Access Factors I 78
5.4 Health Care Access Factors II 79
5.5 Preventive Care: Time and Cumulative Time Since Last Blood Pressure Check 80
5.6 Preventive Care: Time and Cumulative Time Since Last Physician Examination 81
5.7 Preventive Care: Time and Cumulative Time Since Last Dental Examination 82
5.8 Preventive Care: Time and Cumulative Time Since Last Cleaning of Teeth 83
5.9 Reason for Last Visit to Dentist 84
5.10 Preventive Care: Time and Cumulative Time Since Last Vision Screening 85
5.11 Age-Sex Specific Rates for Stay in Hospital in Last 12 Months 86

8

Table of Charts

Continued

6. Financial Issues

6.1 Private Health Insurance, Medicaid and Medicare Coverage 88

6.2 Why Respondent is not Covered by Health Insurance . . 89

CHAPTER 1

Introduction

The health conditions and health status of Hispanics in the United States will assume increased importance as their population increases in the decades to come. In 1970, the U.S. Census Bureau reported approximately 11 million persons of Spanish origin. Almost half (6.6 million) of the Hispanic population lived in the Northeast (New Jersey, New York, Connecticut, Massachusetts). The Hispanic population of the United States is growing nearly *five times faster* than the general public, with one of every 14 Americans now of Spanish background. From 1980 (U.S. Census Data) to 1985 the nation's Hispanic population increased almost 16 percent to 16.9 million persons. In the same period the United States population overall grew by only 3.3 percent. The size of the Hispanic population is reflected also by the number of interviews that had to be conducted in Spanish (See Chate 1.1).

Current census figures indicate an Hispanic population of almost 17 million persons. This figure is generally believed to be an underestimate because of problems related to factors such as an inability to assess accurately the numbers of illegal aliens and establish ethnic identification. There is general agreement, however, that before the turn of the century Hispanics will be the nation's *largest minority group*. The status of their health cannot be simply dismissed or overlooked. Until recently there was no national comprehensive study of the status of Hispanic health conditions.

Previous Studies of Hispanic Health

One of the early and most cited works in vital statistics is that of Moustafa and Weiss (1968) from the School of Public Health at the University of California. Their empirical work of the health status of Mexican Americans also highlighted the need for vital statistics and health data of the Spanish origin population. Moustafa and Weiss used two statewide surveys of vital statistics information (Colorado and California). The Colorado survey was based on mortality data obtained from 1960 death certificates identified by Spanish surname. The California Health Survey done in 1954-1955 is probably the first comprehensive statewide body of morbidity gathered on the Spanish surname population.

One of the few analytical studies on the mortality of Spanish surname persons is a study by Roberts, McBee, and MacDonald (1970) which investigated the interrelationships of social class, ethnicity, and mortality in Houston, Texas. Death records for 1959, 1960, and 1961 were obtained from the local health department. Age-adjusted rates were then analyzed using census tracts to determine social class standing as well as ethnic population proportions per census tract. The study also illustrated the relationship between mortality and various social demographic features.

Juarez (1978) conducted a review of past research conducted on the health status of the Spanish origin population. Although none of the studies dealt with the elderly, the studies helped provide a background on "health history" of a population subgroup. The various studies dealt with neonatal and infant death rates in San Antonio including, lung cancer mortality among Mexican Americans, Blacks, and Anglos, and overall mortality for all three groups. Juarez, similar to Moustafa and Weiss, stressed the need for comprehensive health statistics of the Spanish origin population in the United States. What existed was a number of sporadic and disjointed efforts.

In 1974 congressional mandate PL 94-311 called for the active production of data on the health of America's Hispanics. Despite the intensive efforts during the past decade to develop a body of knowledge there have been significant gaps. The need for baseline data was noted often by researchers and experts in the field (Solis, 1978; Task Panel Reprot, Lecca and Olmedo, to the President's Commission on Mental Health, 1978; Bell, Kassachav and Zellman, 1976).

Beyond the basic data needs on morbidity and mortality, there is need for more comprehensive data. Hayes-Bautista (1978) noted that morbidity and mortality data tell the end result, but little about the process by which those results were obtained. Basic quality of life data such as information about employment, education, income, housing, immigration, and voting participation is also needed. Hayes-Bautista further noted that these data were collected by different agencies, utilizing different population definitions and, without these data, health service programs were likely to end up treating effects rather than causes. A vehicle existed, however, that would enable some of the knowledge gaps to be filled. Since the 1950s The National Center for Health Statistics (NCHS) had conducted several health and nutrition surveys of which the recent Hispanic Health and Nutrition Examination Survey (HHANES) is one.

Health status data on mainland Puerto Ricans is quite sparse. Certain diseases seem to be more frequently represented in Puerto Ricans. Acute respiratory diseases such as asthma were noted to be much more frequent in urban Puerto Ricans (Karetvsky, 1977). Puerto Ricans were also noted to have higher than white premarital first births (Darabi, 1987). Trauma was found to be frequent in Puerto Rican born adolescents and young adults, particularly males (Rosenwaike, 1987). Cancer mortality for cancer of the cervix, esophagus and stomach was found to be higher in mainland Puerto Ricans (Rosenwaike, 1984). Diseases requiring chronic treatment such as hypertension have also been found to be poorly controlled in mainland Puerto Ricans in the urban setting (Muñoz, 1987).

Hispanic Health and Nutrition Examination Survey

The NCHS health survey has as its foundation The National Health Survey Act of 1956, which has been updated periodically since its original passage by Congress. Throughout the history of the National Health Survey, the mandate of the 1956 Congressional Act had been fulfilled for the general United States population with the provision of data on a wide range of health status measures. However, there was a noteable lack of comparable data for the Hispanic population. Previous National Health and Nutrition Examination (NHANES) samples did not include a sufficient number of Hispanics to enable an adequate estimation of their health characteristics.

The goal of the Hispanic Health and Nutrition Examination Survey (HHANES) was to produce, for the three Hispanic subgroups (Mexican Americans, Puerto Rican and Cuban), estimates of health and nutritional status that are comparable to estimates available for the general population. The HHANES was the first special population survey ever undertaken by NCHS, and probably the last, based on the cost of its development and implementation. The HHANES relied on five principal data collection methodologies: physician examinations, diagnostic testing, anthropometry, laboratory analysis, and personal interviews. It is important to note that HHANES data can be compared with data collected from the general population through NHANES, the National Health Interview Survey, the National Survey of Family Growth and other federally sponsored surveys.

The major difference between HHANES and other HANES data is that the HHANES is a survey of three special subgroups of the population in selected areas of the United States. The HHANES was a probability sample consisting of civilian non-institutionalized Hispanics (Mexican Americans in the Southwest, Puerto Ricans in New York City, and Cuban Americans in Dade County, Florida).

Goal and Objective of the Chart Book

The goal of this chart book is to present data from the HHANES, with the most up to date information on Puerto Ricans in chart form for researchers, agencies, organizations, public and private and community groups interested in this profile of data.

The objectives are:

- to present a current profile of Puerto Ricans in the United States
- to present a pictorial view of the HHANES data
- to stimulate additional research, and
- to provide a basis for analysis and discussion.

It is hoped that this chart book will serve as a beginning resource for the many Hispanic researchers seeking data on this population group, as well as those groups seeking justifications for statistical analysis or program development.

Finally, the authors have expectations of publishing other volumes from the Mexican and Cuban American data of the HHANES.

Design of The Puerto Rican HHANES Sample

The Puerto Rican HHANES sampling procedure is a multistage probability sample of civilian non-institutionalized Puerto Ricans in New York City. The HHANES Puerto Rican original universe of 193 first stage sampling units (counties and county groups) or Primary Sampling Units included about 84 percent of the 1980 Puerto Rican population of the United States.

The 193 Primary Sampling Units were then stratified on the basis of number of Hispanics, percent Hispanic, ratio of the 1980 to 1970 Hispanic population, median income, and percent urban based on 1980 Census of Population and Housing estimates. Fourteen Primary Sampling Units were then selected for inclusion in the sample: from the New York City Metropolitan area (a 20 million population base).

At the Primary Sampling Unit level, block groups and enumeration groups were stratified on the basis of an economic index and Hispanic density. Secondary sampling units were then selected on the basis of age distributions within SSU's. Within secondary sampling units households had an approximately equal probability of inclusion in the sample.

After sample households had been identified, the ethnic composition of the household was determined by interviewers using the Household Screener Questionnaire to select eligible Puerto Rican origin families. Members of the families were selected using an oversample of those individuals under 20 years of age and those 45 to 74 years of age.

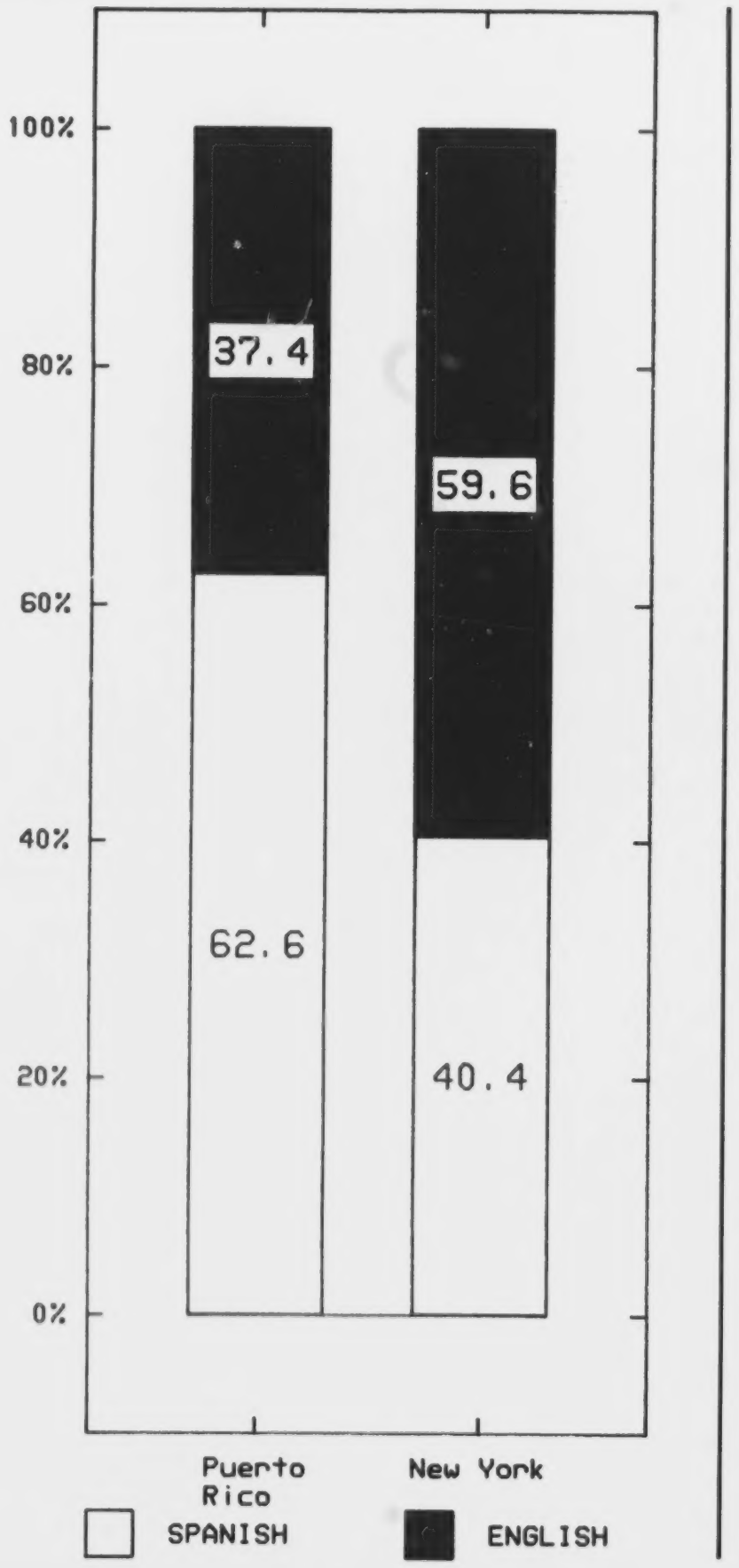
The actual interviews and examinations were conducted from July 1982 through November 1983. Of the 3,786 persons included in the sample, 3,369 were interviewed; of these, 2,834 were examined.

The data reported in this monograph reflect only those Puerto Rican origin HHANES respondents 18 years of age or older. With the exception of Chart 1.1 (which reports sample data in terms of numbers of respondents) all charts reflect the estimated population values based on sample values and the appropriate sample weights. Thus, the percentages and means reported are population estimates.

1.1

Number of Completed Interviews by State of Residence and Language of Interview

The vast majority of Puerto Ricans were born either in Puerto Rico or New York State. Of those who were born in Puerto Rico, 62.6% of those interviews were conducted in Spanish, while only 40.4% of those persons born in New York, had interviews conducted in Spanish.



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CHAPTER 2

Sociodemographic Context

The Hispanic population of the United States, according to recent Census Bureau data, consists of over 16 million persons of Spanish ancestry. Mexican Americans represent the largest subgroup, numbering 10 million. there are 3.3 million Puerto Ricans living in Puerto Rico who are citizens of the United States and over 2 million living in the continental United States (i.e., mainland), 1 million Cuban Americans, and 3 million other Hispanics in the United States.

Hispanics, having a median age of 23 years, are younger than the United States population as a whole. The median age for Mexican Americans and Puerto Ricans is 22, and their numbers are increasing rapidly. About 6% of families have six or more children. It is projected that Hispanic Americans will comprise *the largest minority group in the United States* by the year 2000.

Puerto Ricans in the United States have limited education. Five percent have completed three years or less of schooling, 15% completed six years or less, and 49% had completed some high school. This pattern is changing. In 1970, 45% were high school graduates, in 1983, 59% had graduated from high school In 1970, only 5% of Hispanics were in college, by the mid-80s the proportion increased to 10%

Hispanics live in every state, but 60% are concentrated in the five southwestern states of Arizona, California, Colorado, New Mexico, and Texas. In 1980, more than 50% resided in Texas and California. One-third of the population of New Mexico is Hispanic. One-fifth of the population of Texas and California is Hispanic. New York has a large concentration of Hispanics (predominantly Puerto Rican) in the New York City area. One-tenth of the population of Texas and California is Hispanic. One-tenth of the population of Arizona, Colorado, Florida and New York is Hispanic. Other states with over 50,000 Hispanics are Illinois, Indiana, Washington, and Ohio.

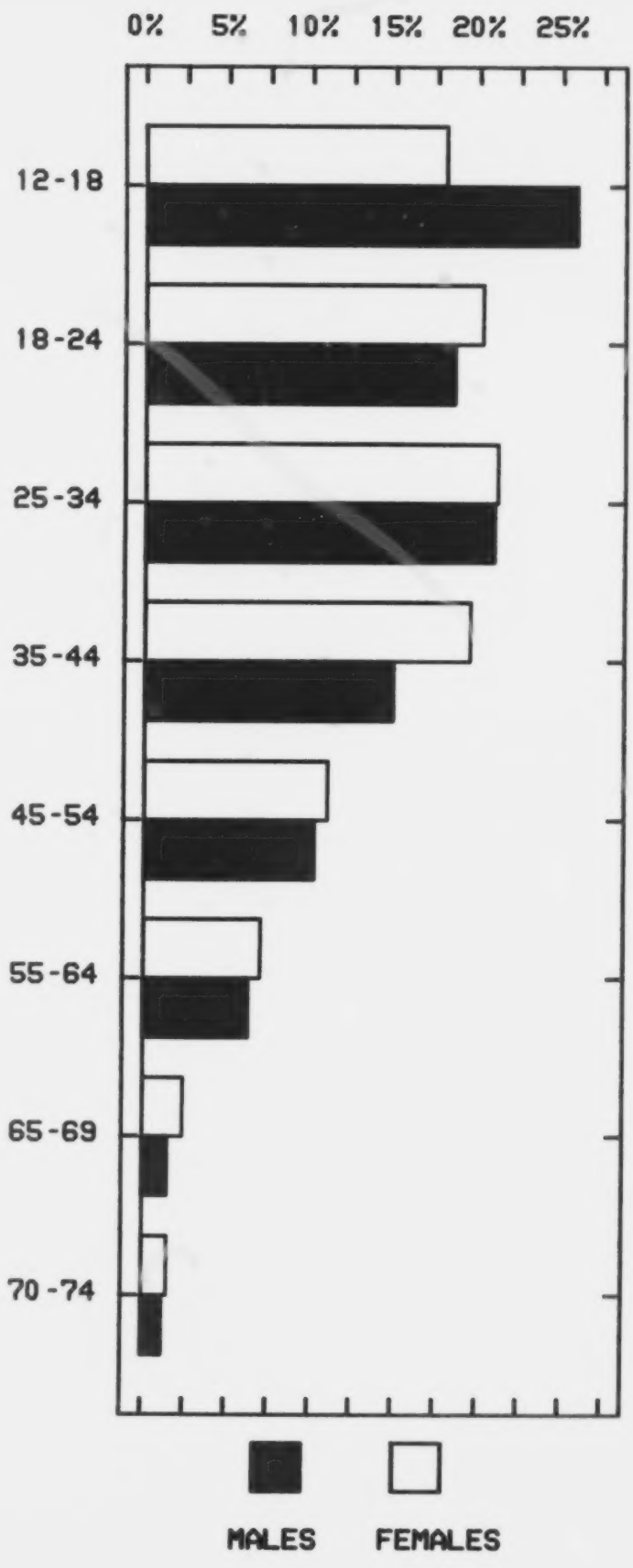
Sixteen percent of Puerto Ricans have a combined family income of $5,000 or less and 48% had incomes below the poverty level.

Twenty-six percent of the sample reported four people in their family, and 67% had four or less. Examining the generational and nationality factors of Puerto Ricans, 40% said they were born in the United States, and 60% in Puerto Rico.

2.1

Population Chart

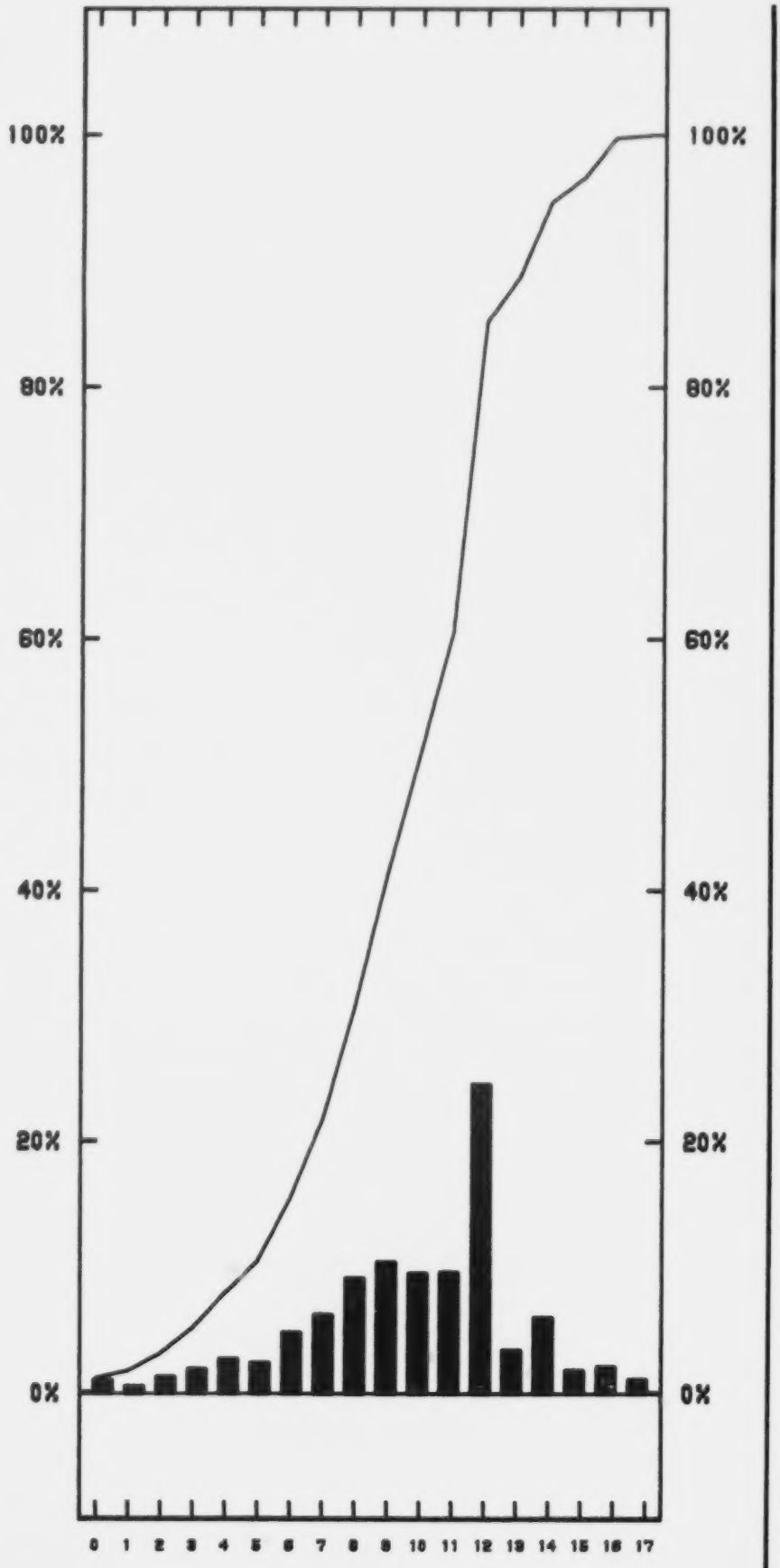
Over all, 3.4% of the sample's population were over the age of 65.



2.2

Educational Attainment in Years

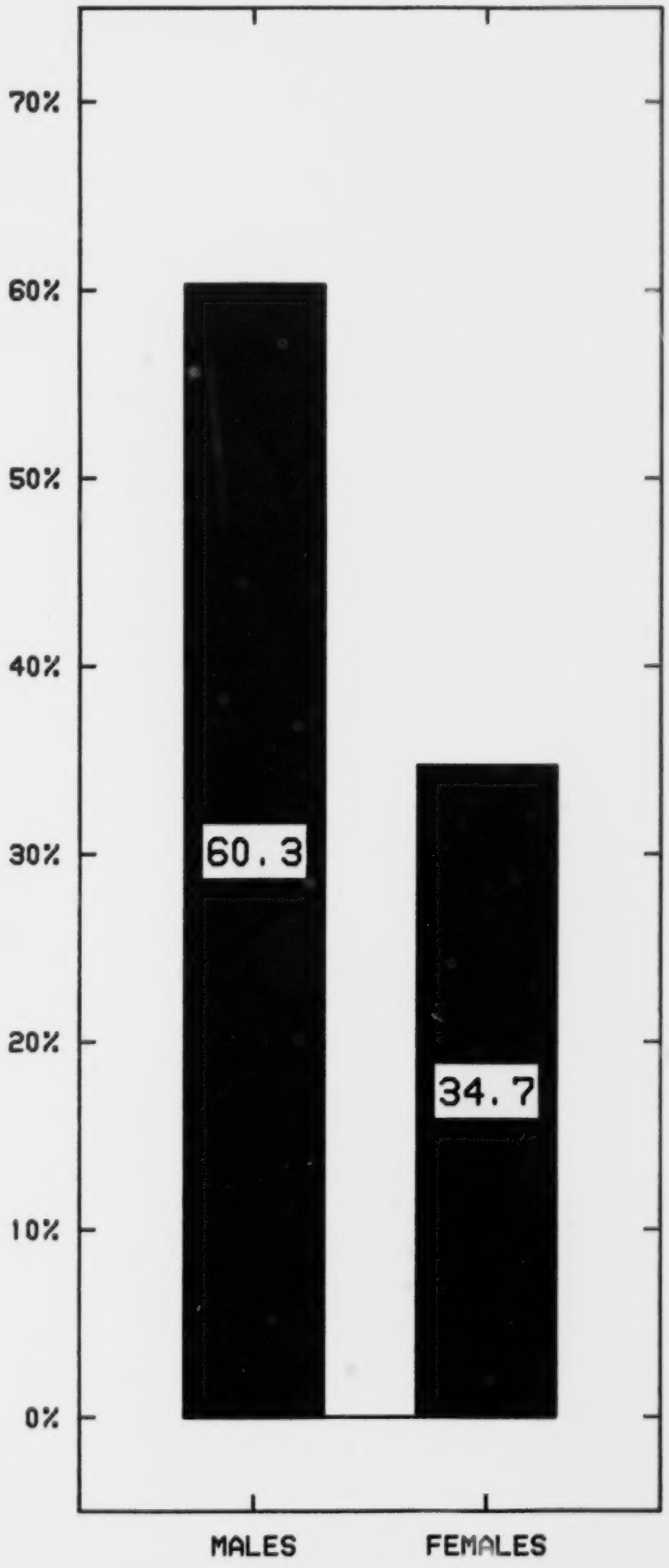
The modal level of education was 12th grade. Mean educational level was 9.8th grade, however.



2.3

Labor-force Status by Sex

Sixty percent of males and 34% of females were working during the two weeks prior to the interview

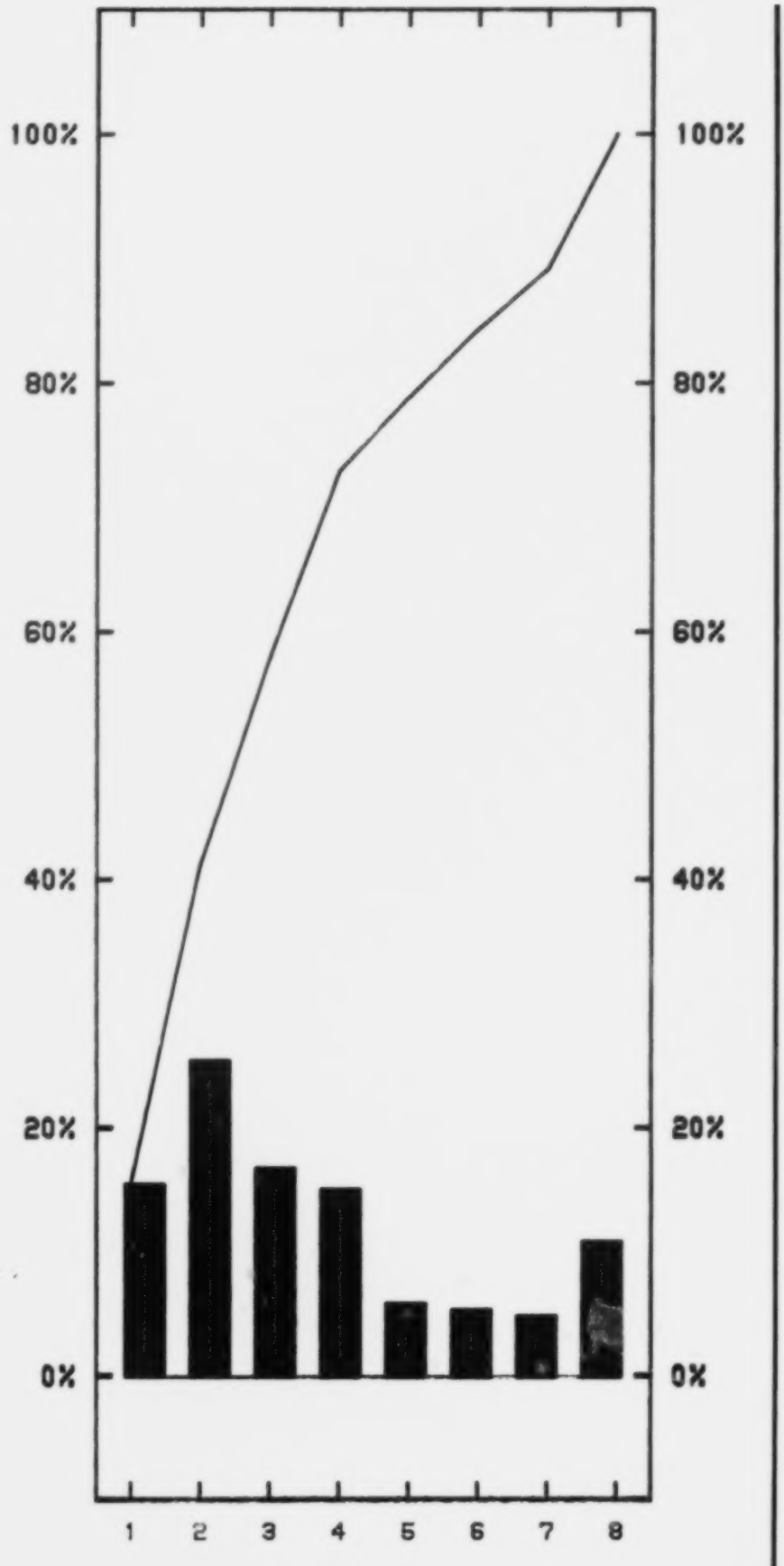


2.4

Family Income and Cumulative Family Income

Approximately 79% had family incomes below $25,000.

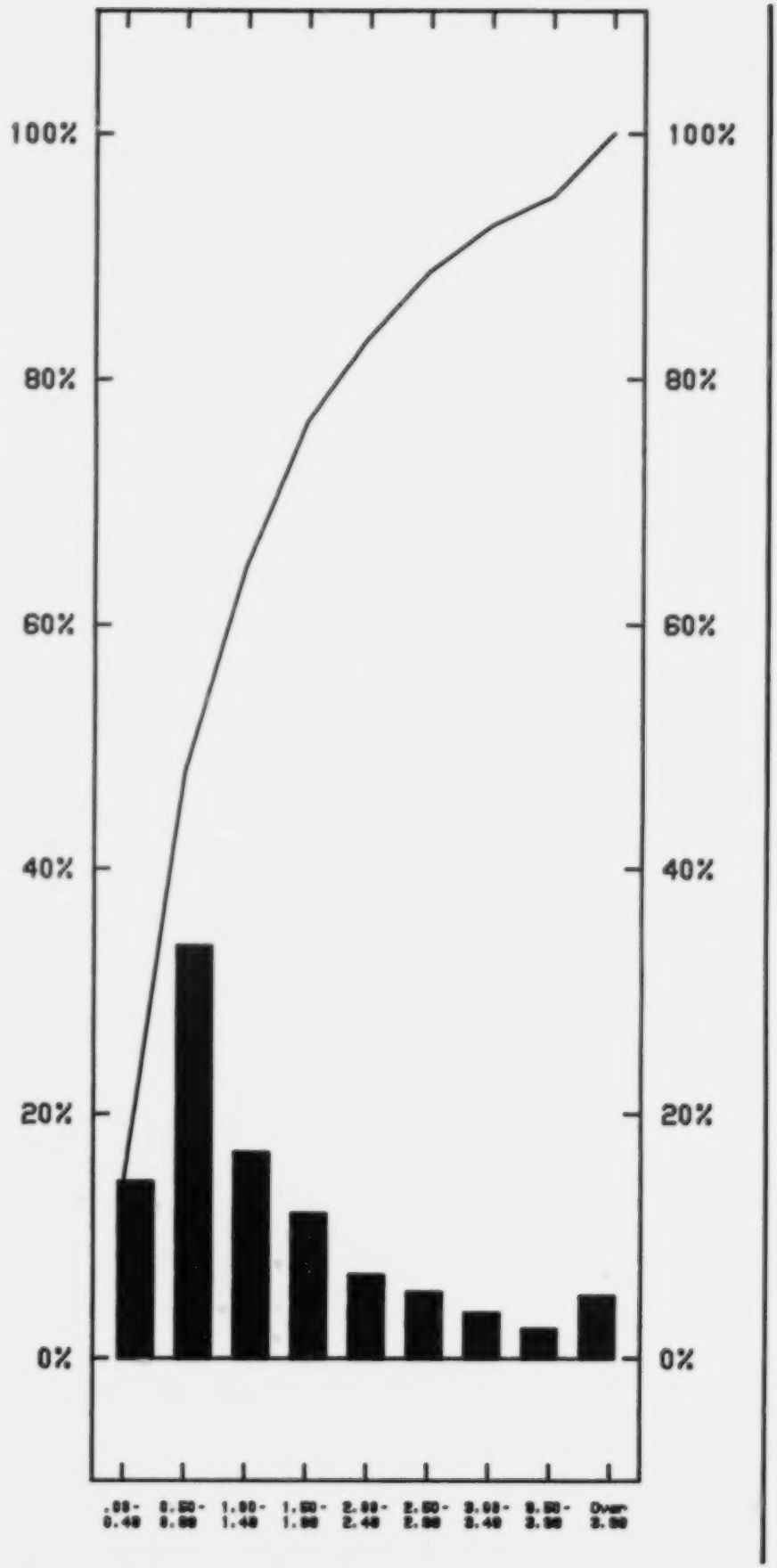
1 = under $5,000
2 = $5,000 - 9,999
3 = $10,000 - 14,999
4 = $15,000 - 19,999
5 = $20,000 - 24,999
6 = $25,000 - 29,999
7 = $30,000 - 34,999
8 = $35,000 and over



2.5

Distribution and Cumulative Distribution of Households by Poverty Index

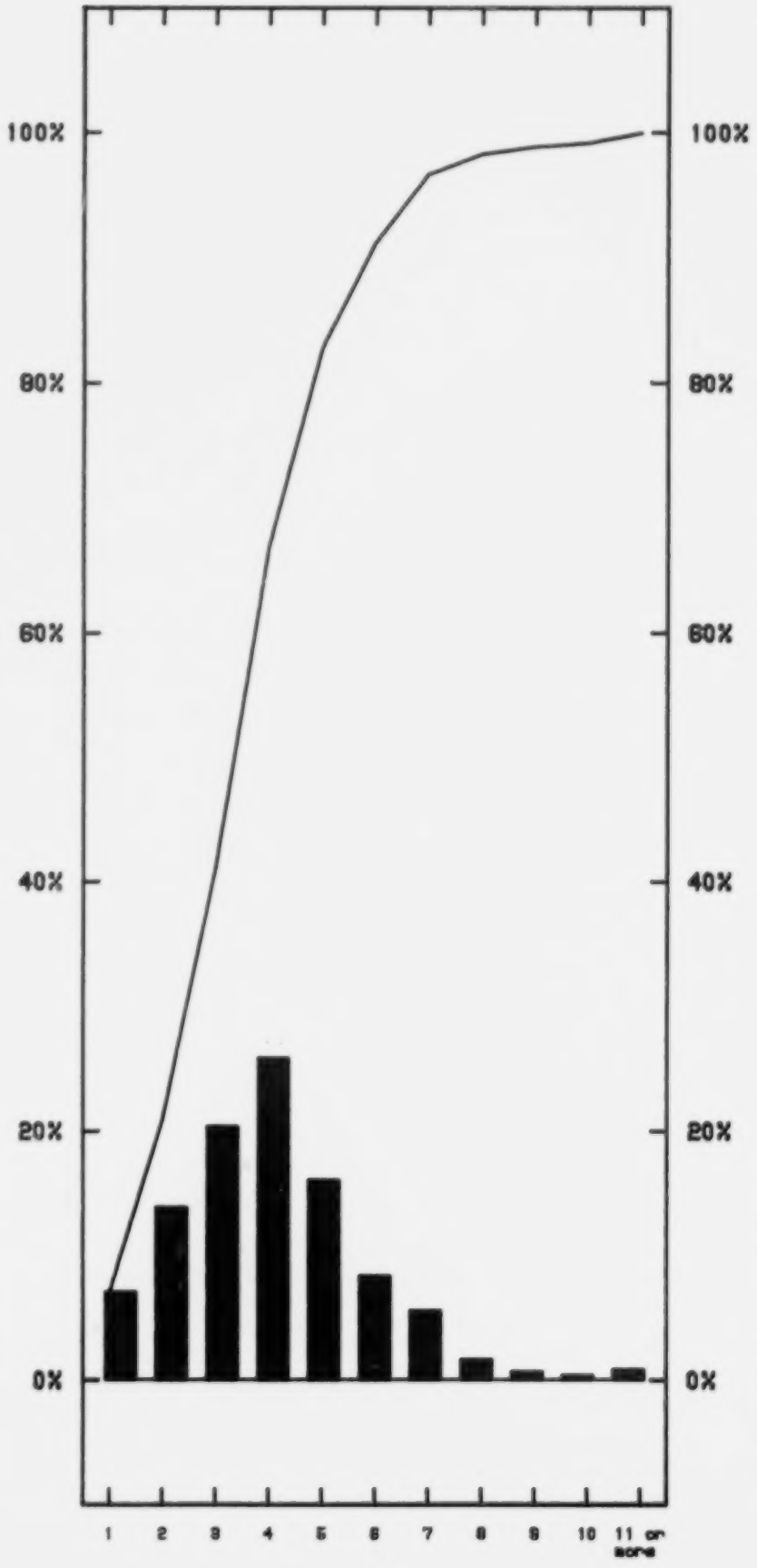
Forty-eight percent of the respondents were below the poverty level.



2.6

Family Size and Cumulative Family Size

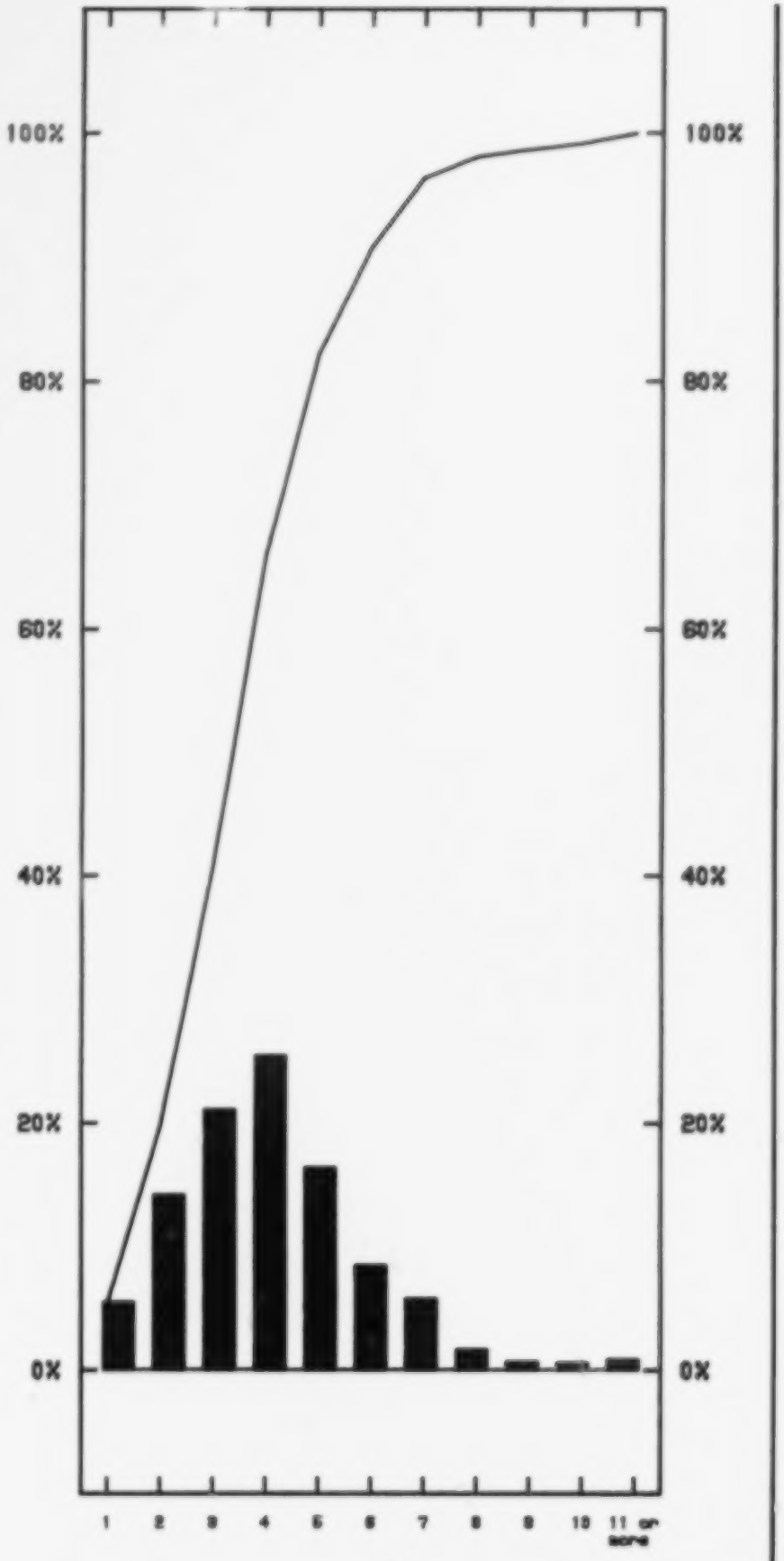
Sixty-seven percent of the respondents reported four people or less in their families.



2.7

Household Size and Cumulative Household Size

Sixty-six percent of the respondents indicated 5 people or less living in their household.



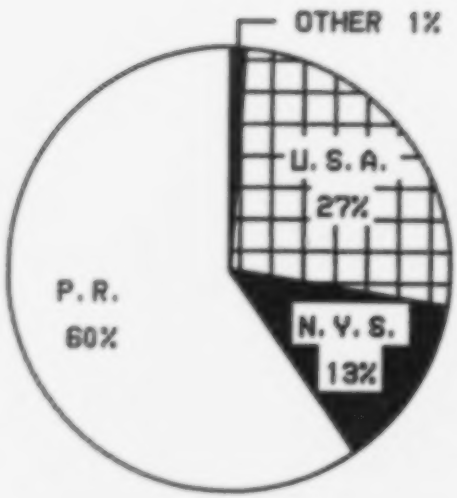
2.8

Place of Birth and Ancestry

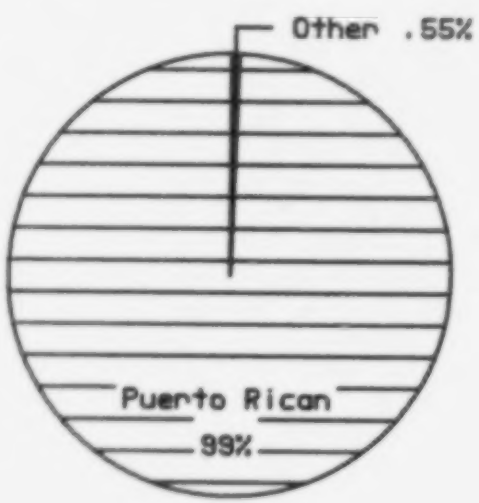
a.
Approximately 40% were born in the United States and 60% in Puerto Rico.

b.
Almost all of the respondents claimed Puerto Rican ancestry.

Place of birth



Ancestry



CHAPTER 3

Health Status

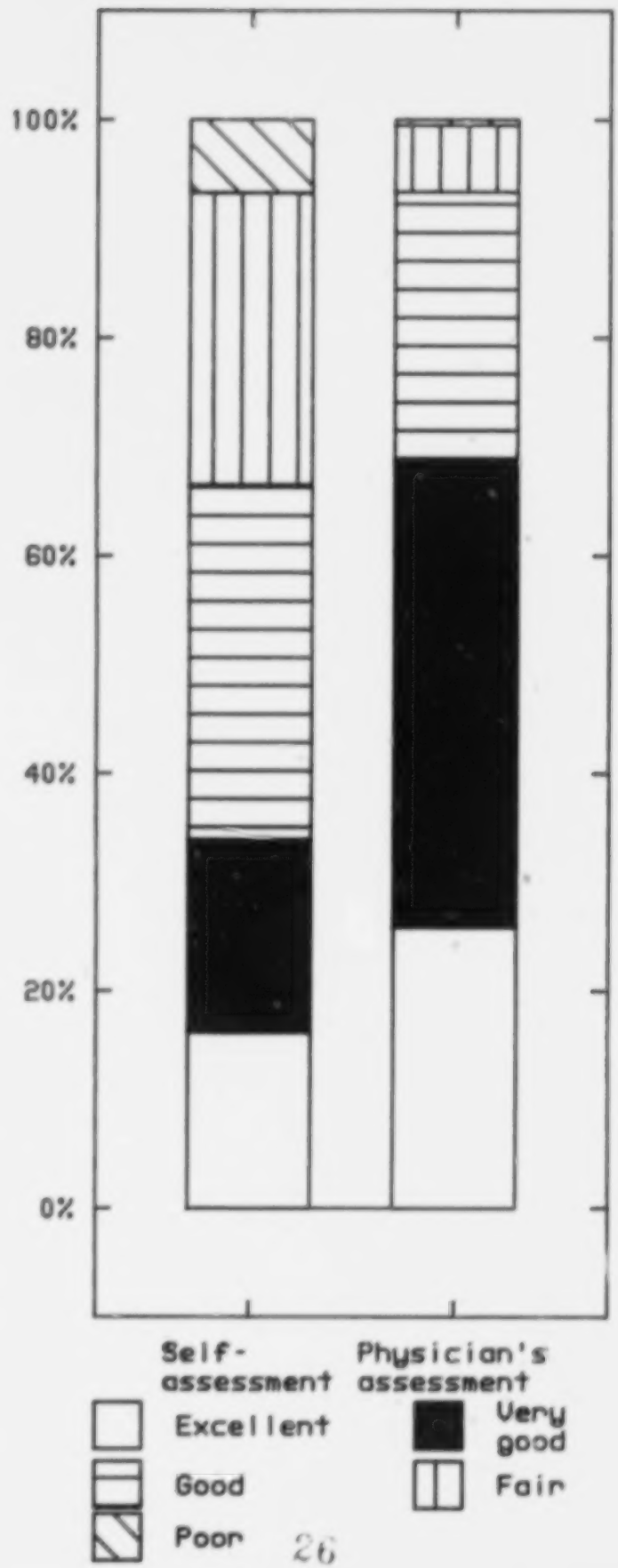
Many of the charts in this section compare the health status rates of males and females overall and relative to age levels. Females report higher rates of health problems than do males in a significant number of disease catagories. No attempt is made to explain this variation, however, the authors believe there is a pressing need for further study in this area that goes beyond the descriptive presentations made in this document.

Although health care utilization rates are given in another section the reader will likely be interested here in the failure of some respondents to seek medical evaluation for conditions that are considered severe and/or life threatening. This pattern is also seen relative to routine prevention medical procedures. It poses a particularly interesting proposition when this avoidance tendency is considered in combination with the fact that respondents perceive themselves as being in poorer health than the physicians who examined them. Medical compliance rate data also provides additional insight into understanding Puerto Rican health status.

3.1

Self-assessment and Physician's Assessment of General Health Status

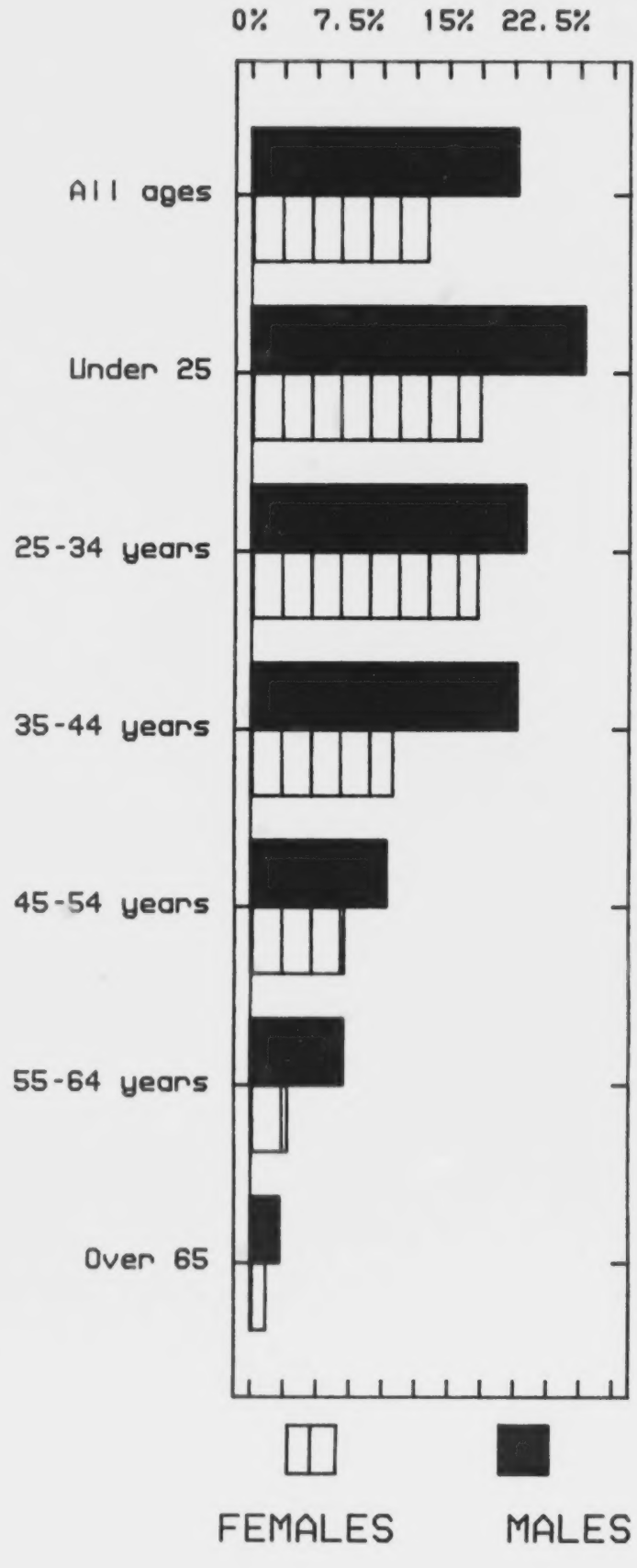
Subjects perceived themselves to be in poorer health than did the physicians who examined them.



3.2

Age-Sex Specific Rates for "Excellent" Health Status

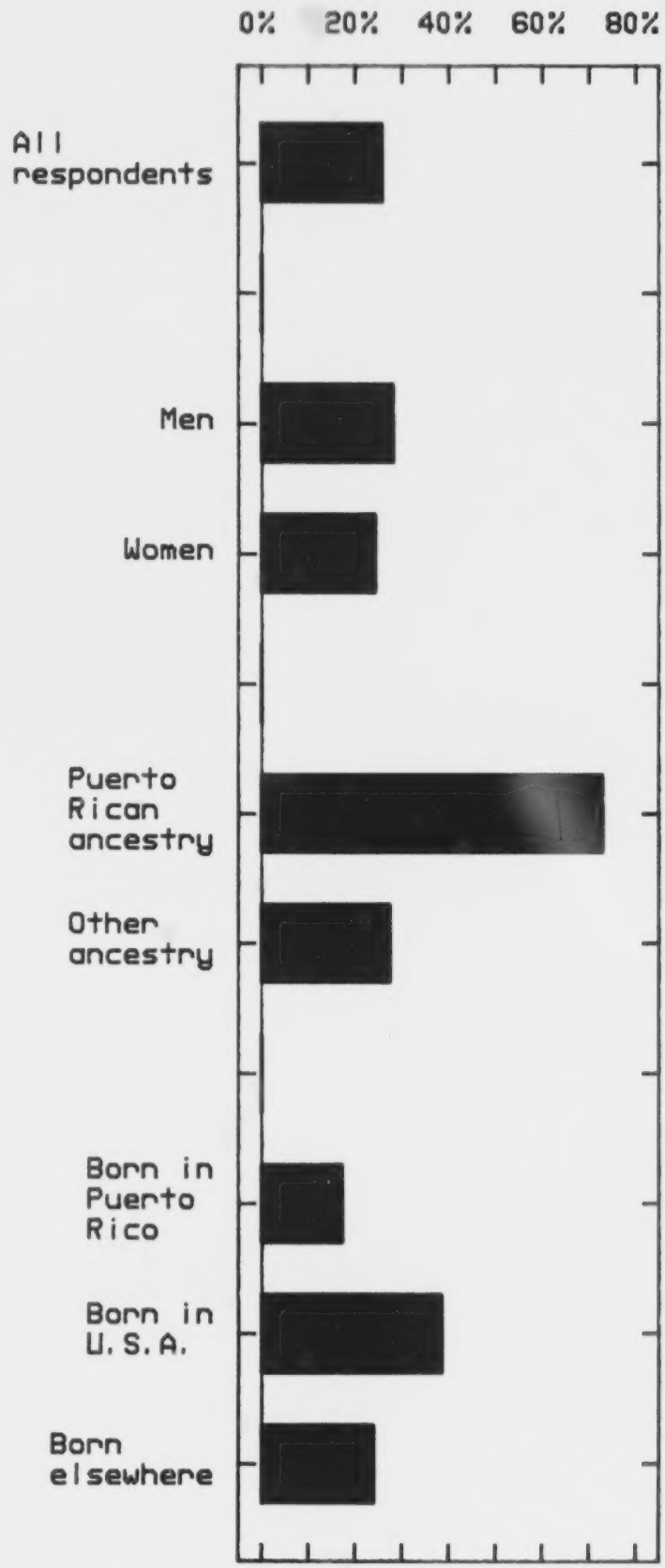
Males had more frequent excellent health ratings compared to females.



3.3

Relationship of General Health Status to Sex, Ancestry, and Place of Birth

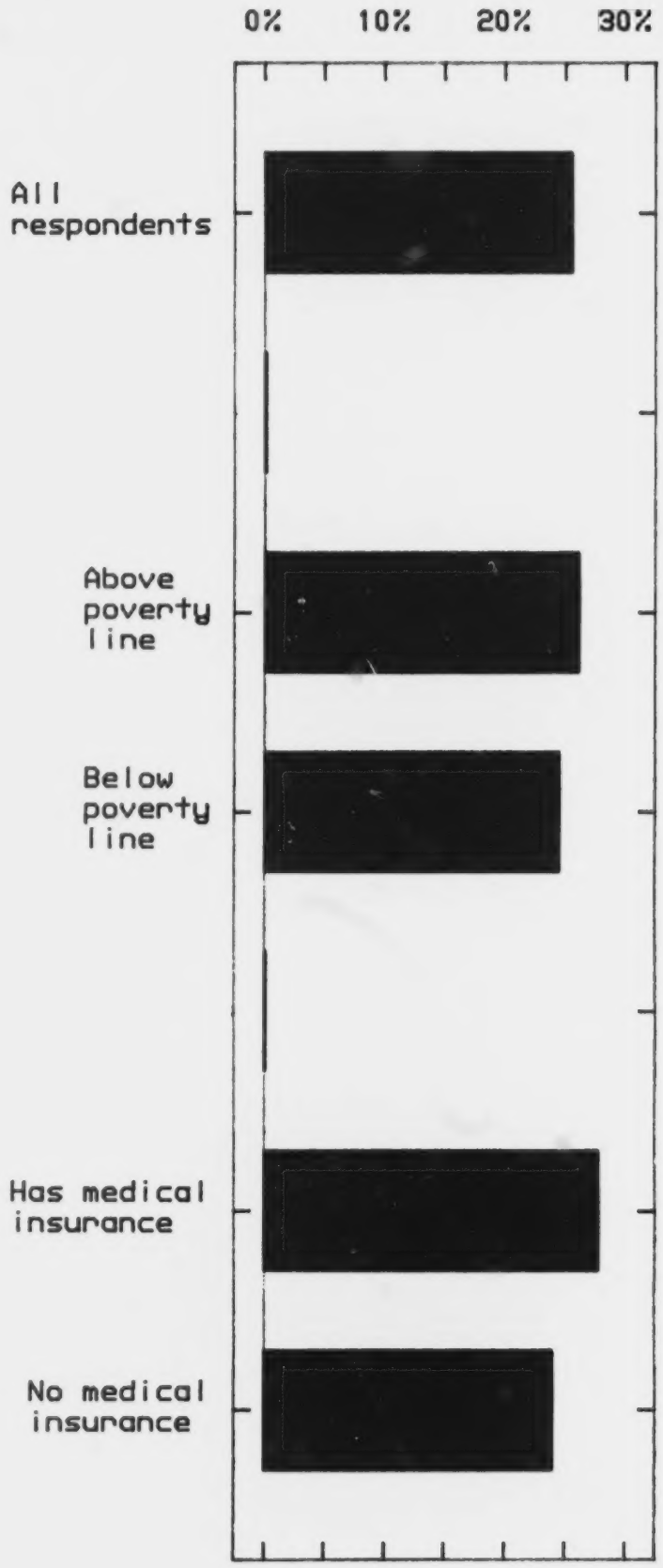
Men were generally in better health than women. Individuals born in the USA were healthier than those born elsewhere.



3.4

Relationship of General Health Status to Poverty Level and Health Insurance Coverage

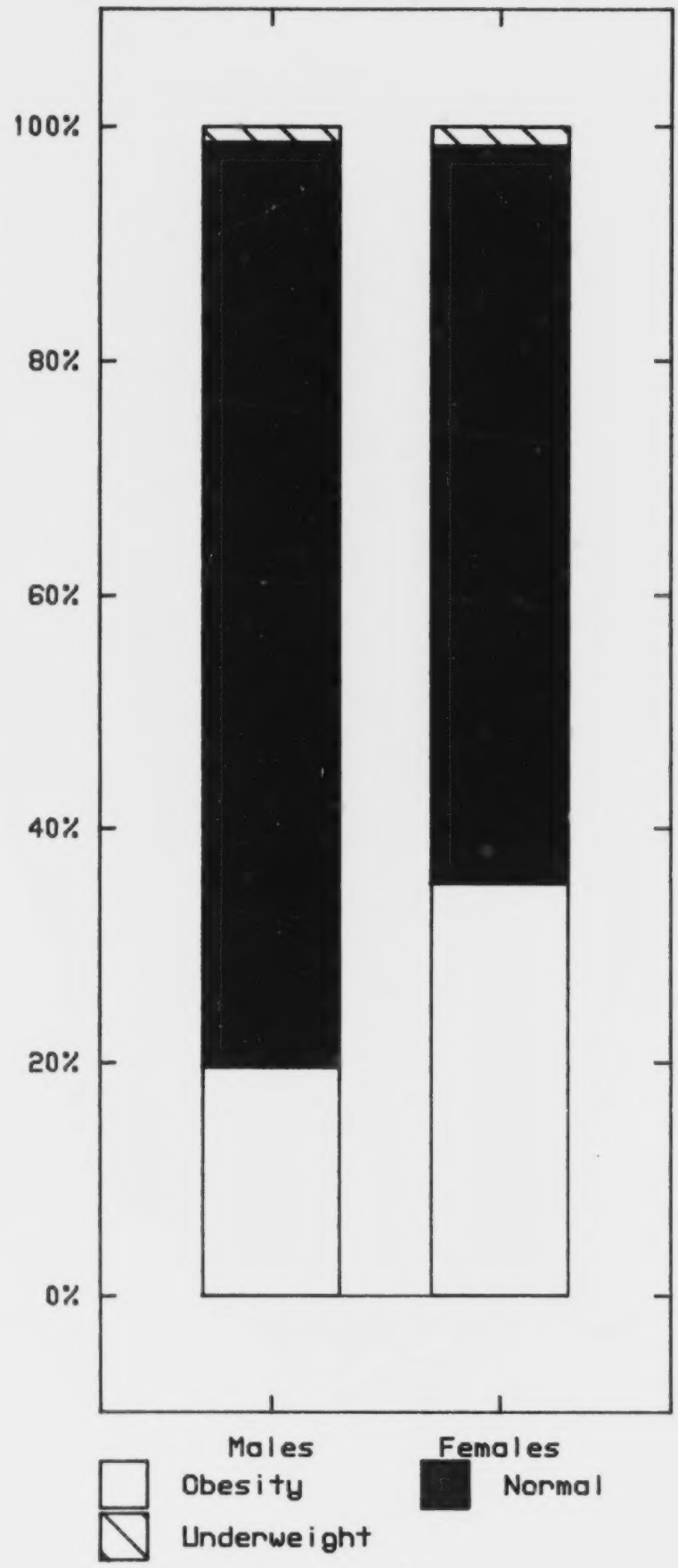
Excellent health ratings were more common for those above the poverty line. Excellent ratings were positively related to the presence of insurance coverage.



3.5

Physician's Assessment of Weight Status

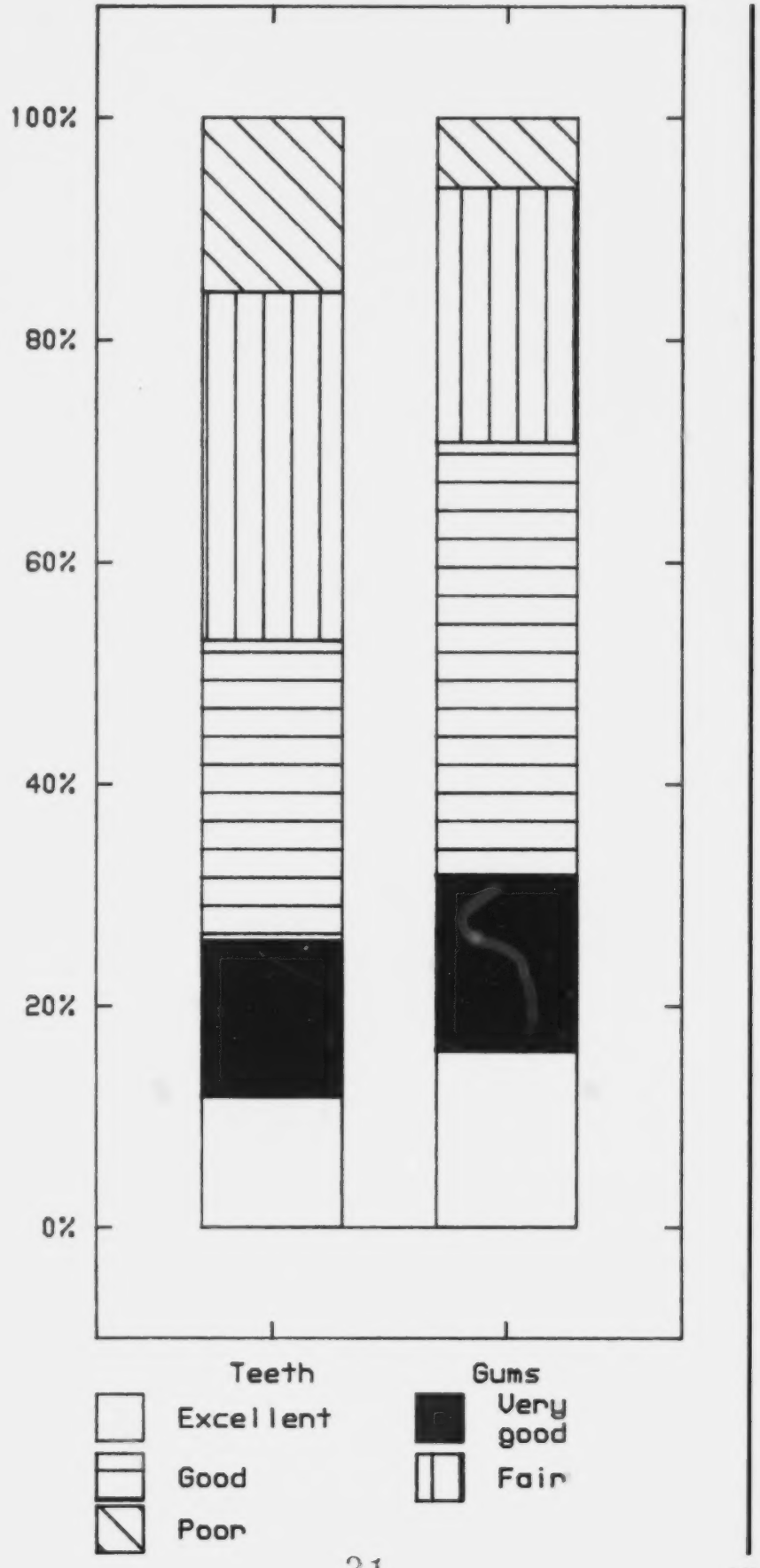
Obesity was more common among females.



3.6

Self-assessment of Condition of Teeth and Gums

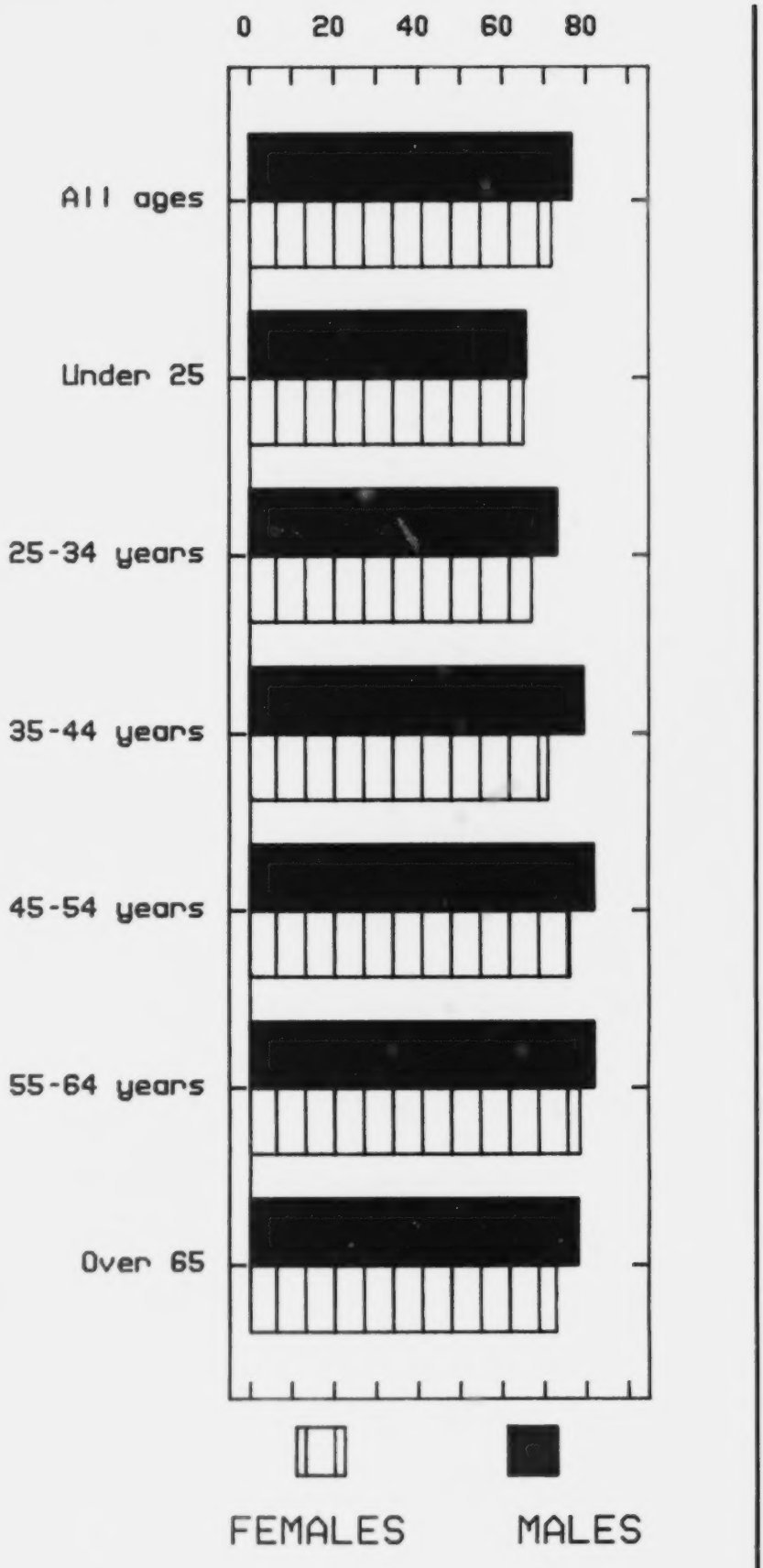
Over 50% rated their teeth as between good and excellent and over 70% rated their gums as between good and excellent.



3.7

Age-Sex Mean Diastolic Blood Pressure Levels

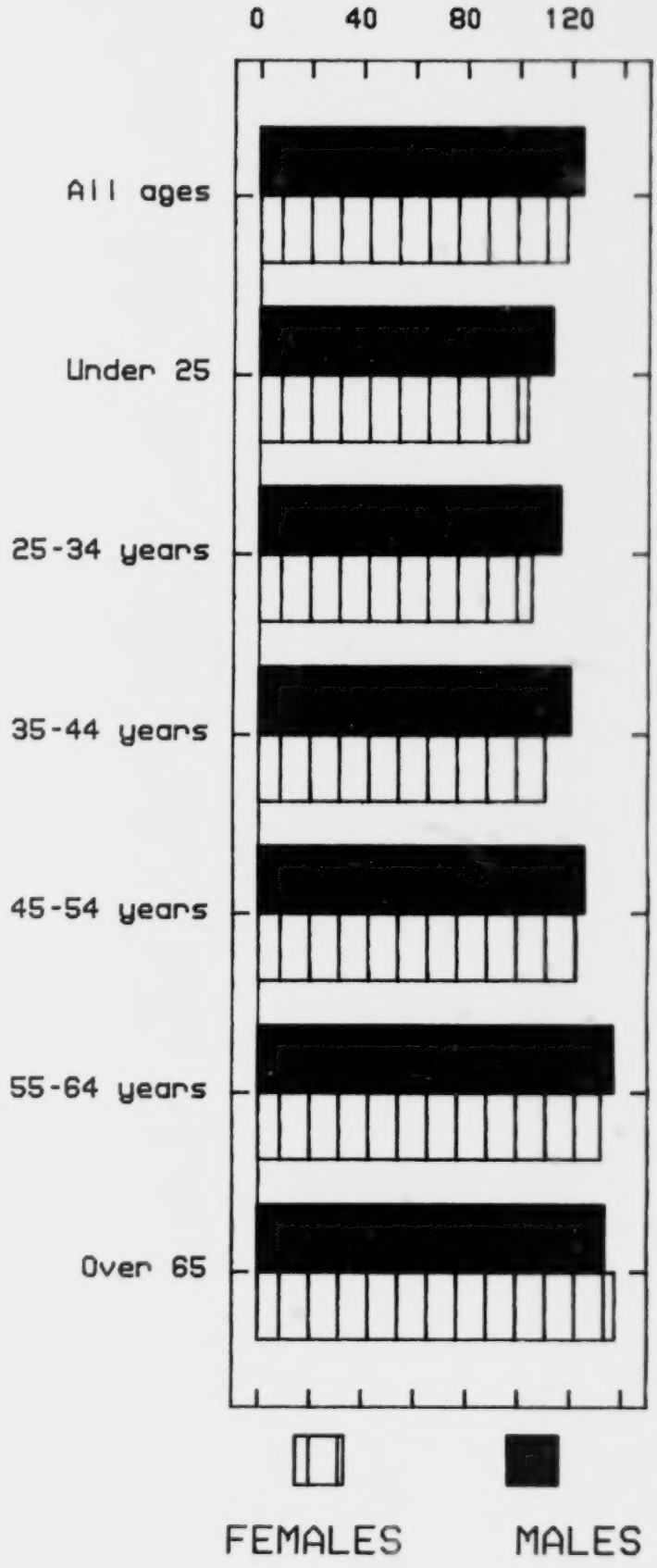
Diastolic pressure was higher for males.



3.8

Age-Sex Mean Systolic Blood Pressure Levels

Systolic pressure was higher for males.

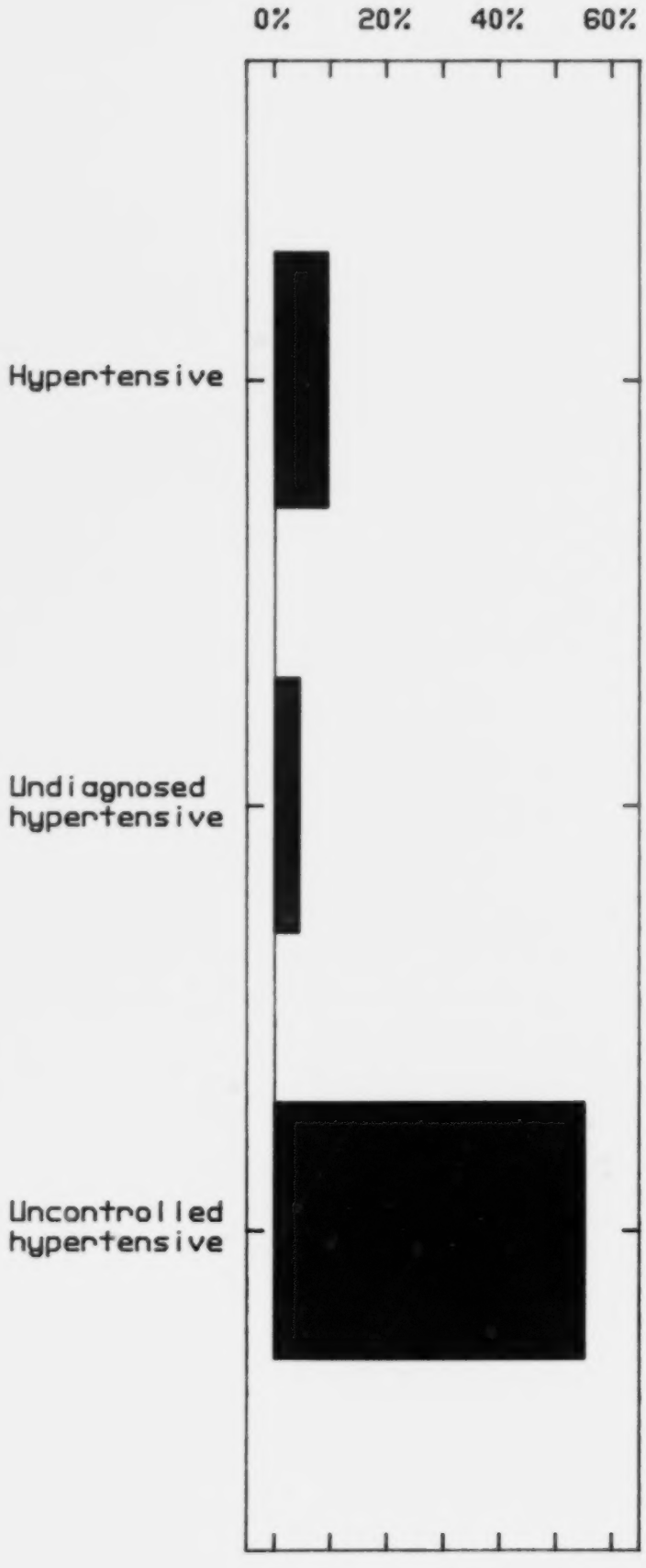


3.9

Previously Underdiagnosed Hypertension, Control of known Hypertensives

Almost half of those surveyed with hypertension, did not know they had it.

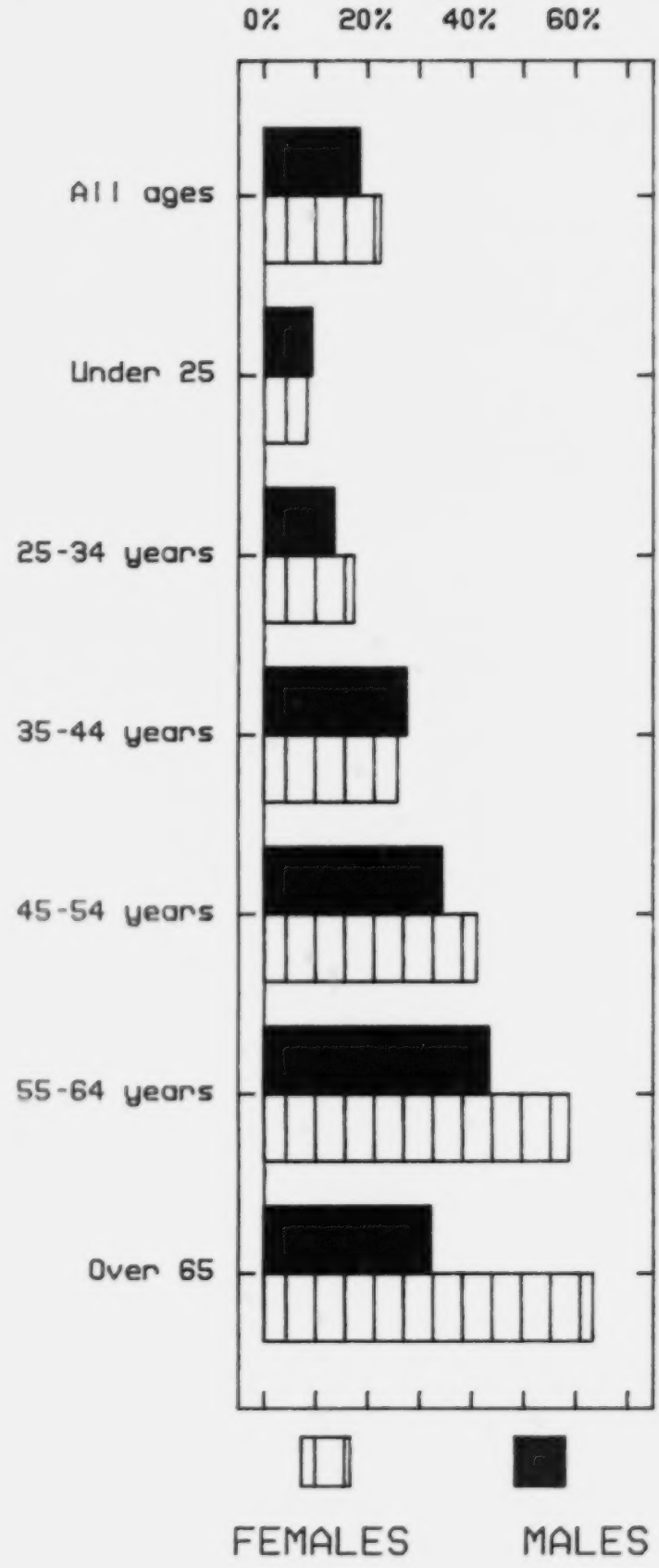
Of those taking medication for hypertension 55% were not under control.



3.10

Age-Sex Specific Rates for Diagnosis of Hypertension

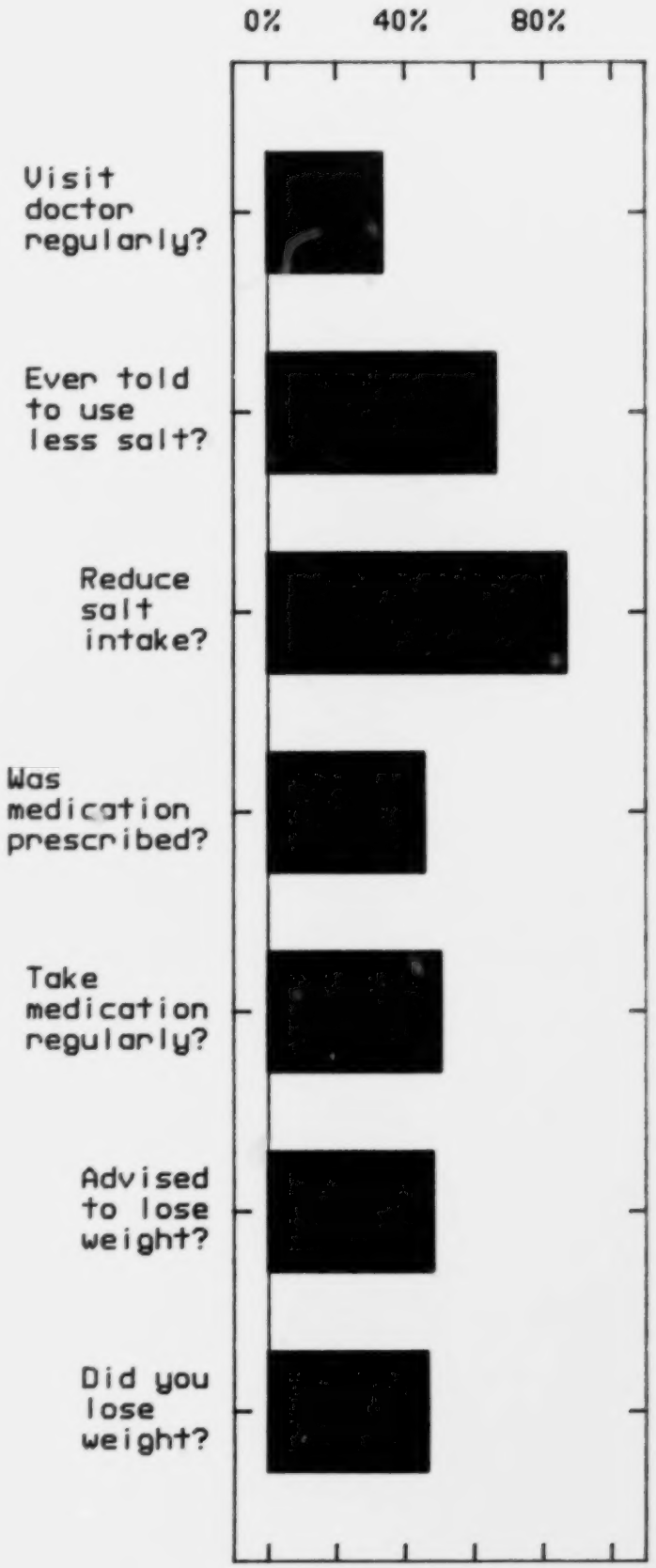
Females were more likely to be hypertensive than males. Especially from age 45 and above.



3.11

Salt Reduction, Use of Medication, and Weight Control by Hypertensives

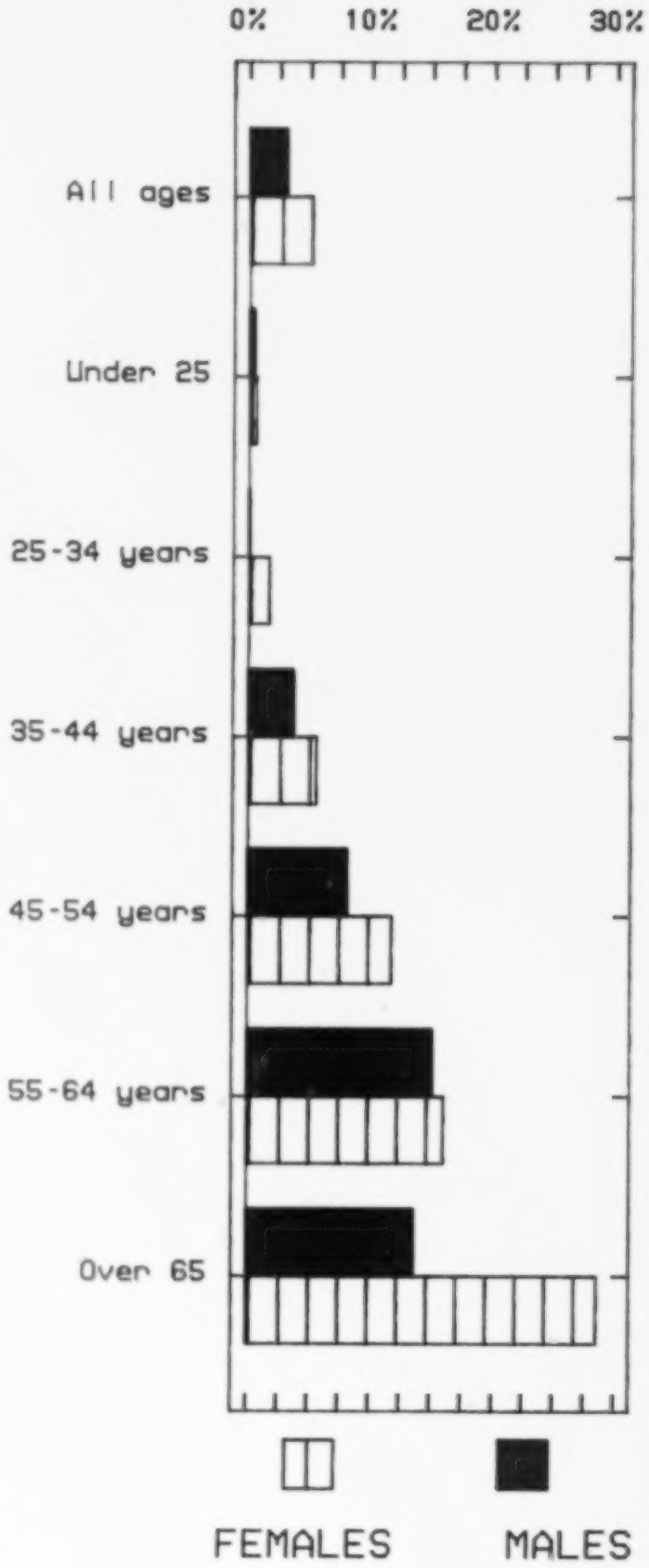
Compliance rates were higher for salt intake reduction than for medication usage and weight loss.



3.12

Age-Sex Specific Rates for Diabetes

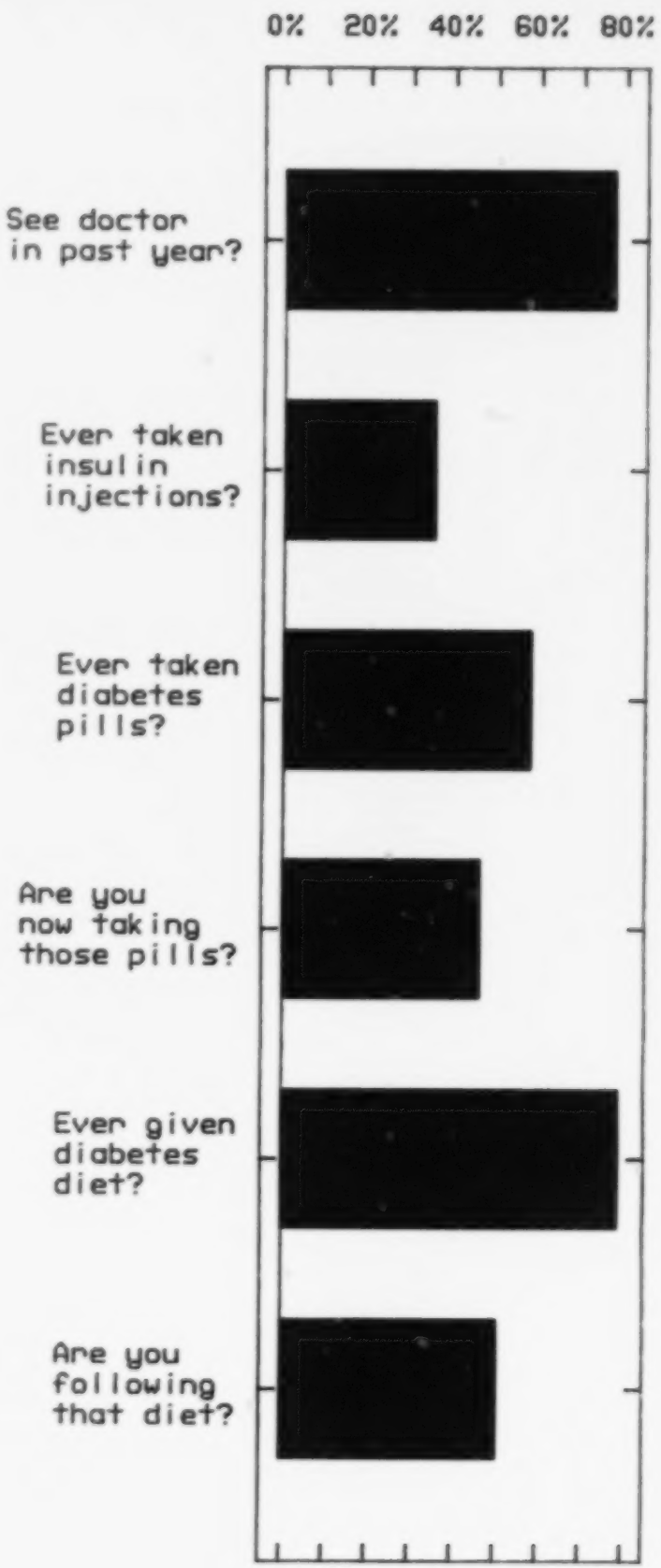
Three percent of males were diabetic contrasted with about 5% of females.



3.13

Insulin, Injections, Use of Medication, and Dietary Practices by Diabetics

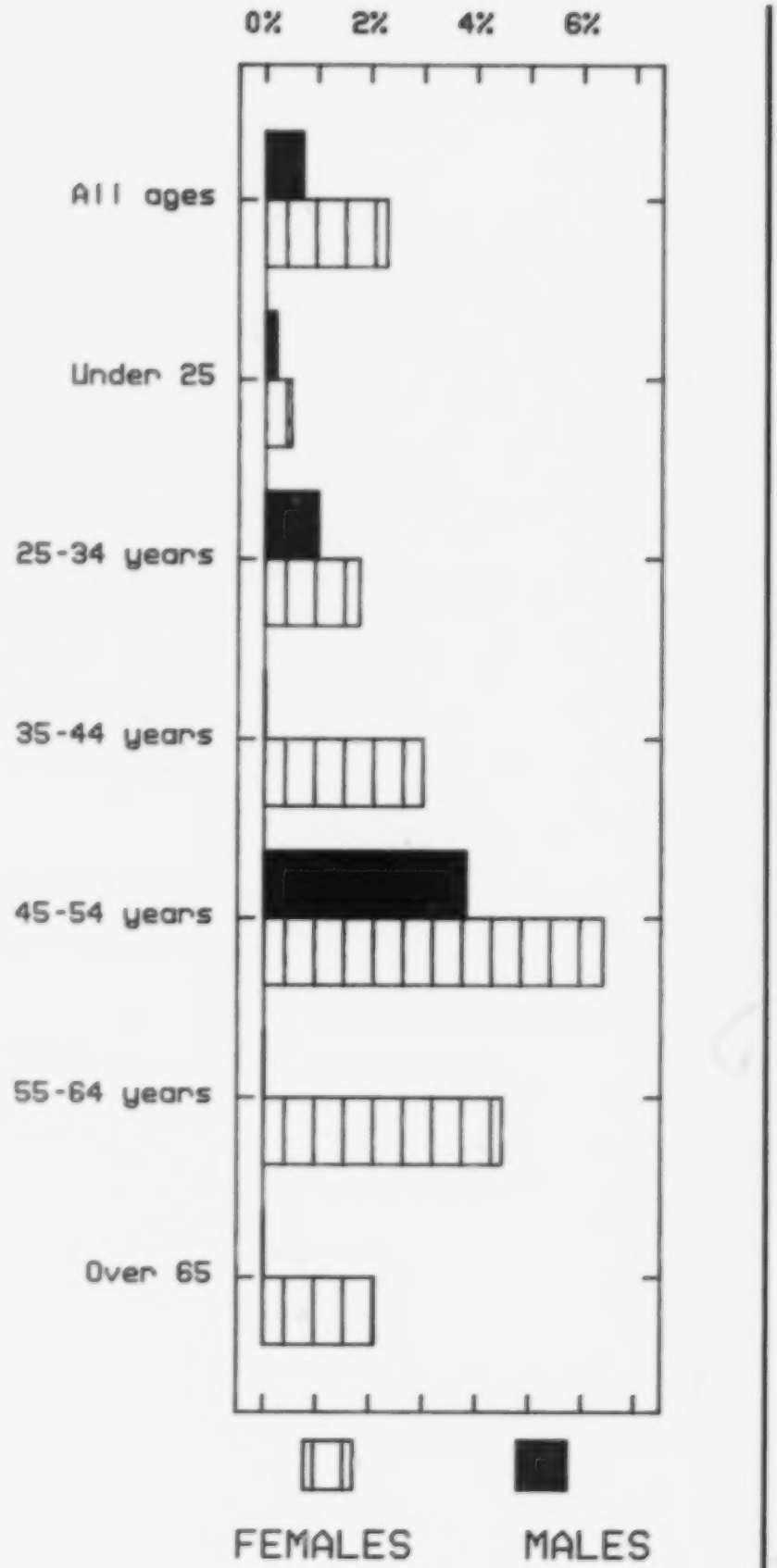
More diabetics were controlled by pills or diet than by insulin injections.



3.14

Age-Sex Specific Rates for Diagnosis of Tuberculosis

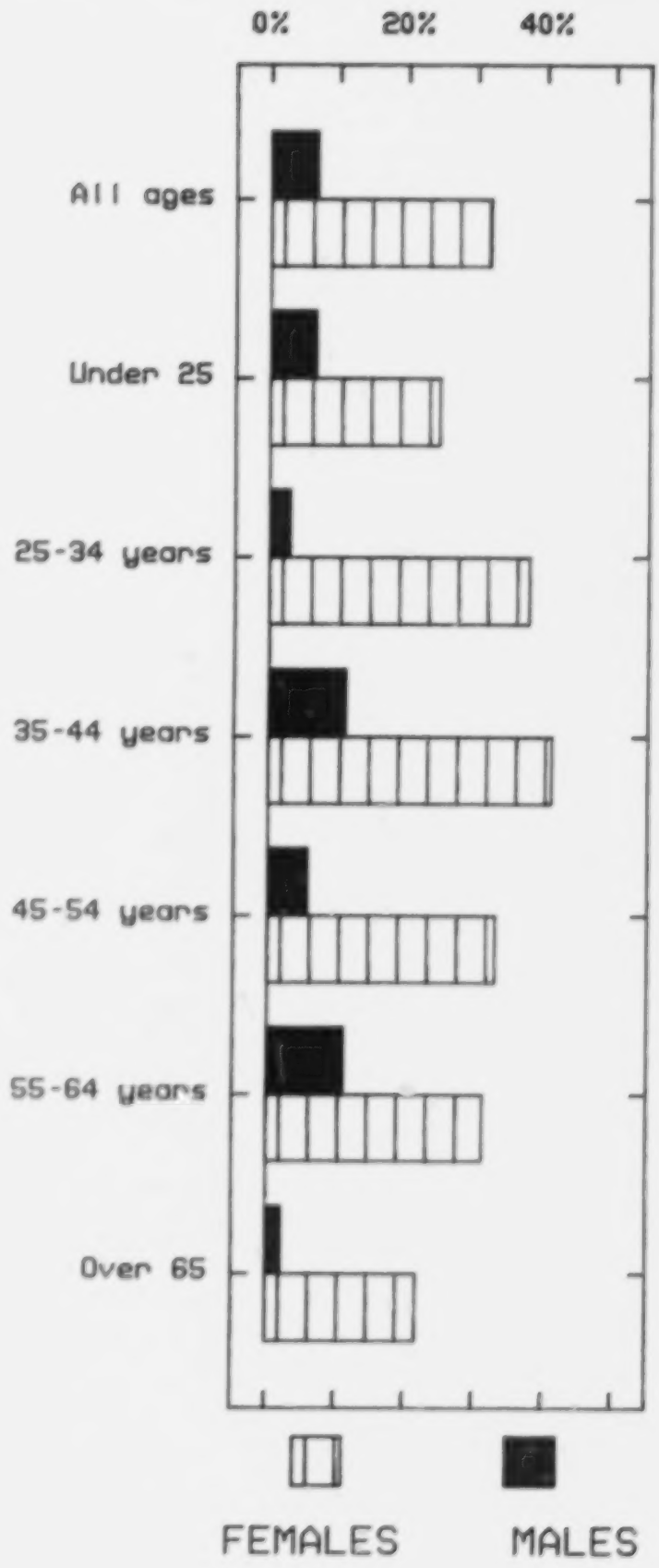
Females had a higher tuberculosis rate than did males.



3.15

Age-Sex Specific Rates for Anemia

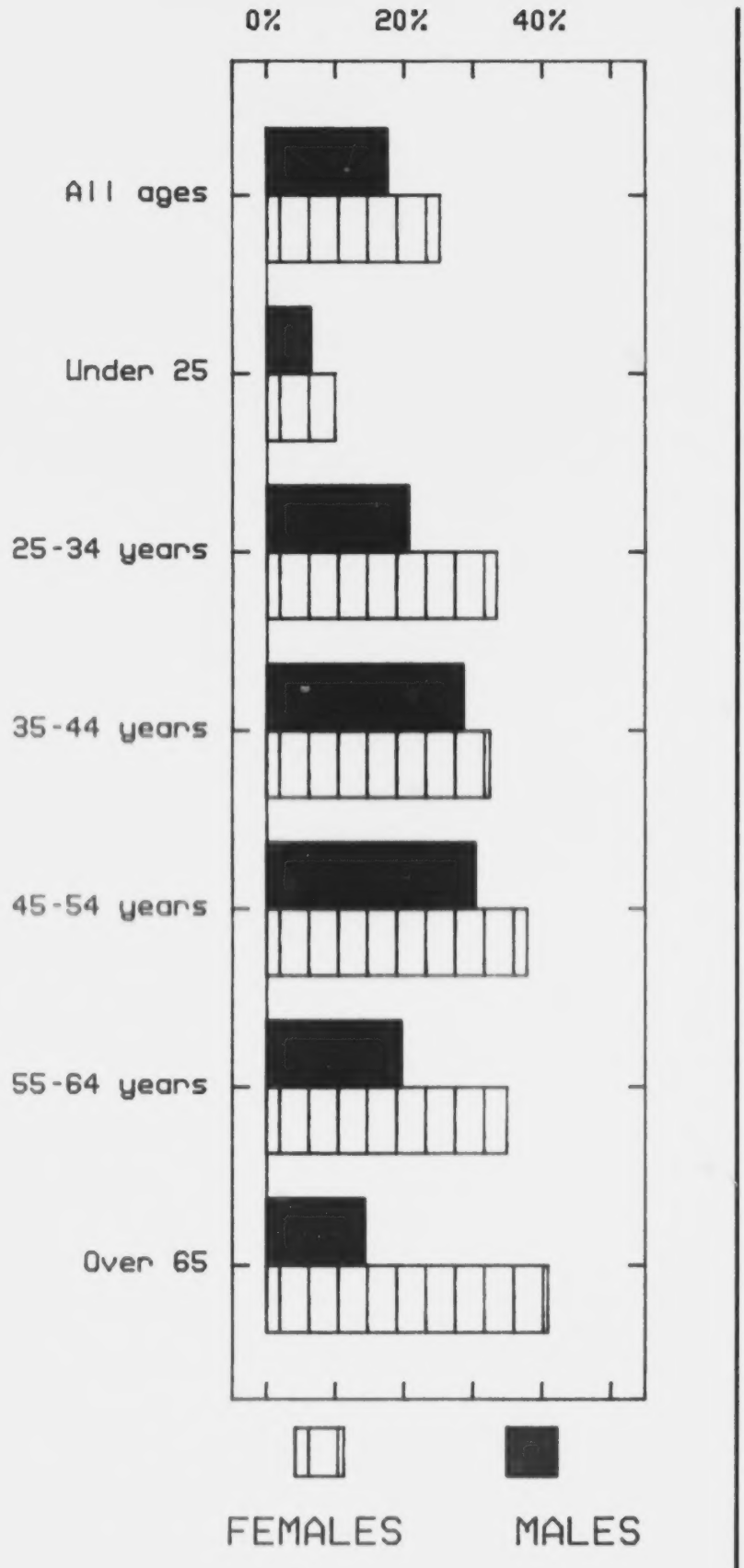
At every age level many more females were anemic than were males.



3.16

Age-Sex Specific Rates for Chest Pain

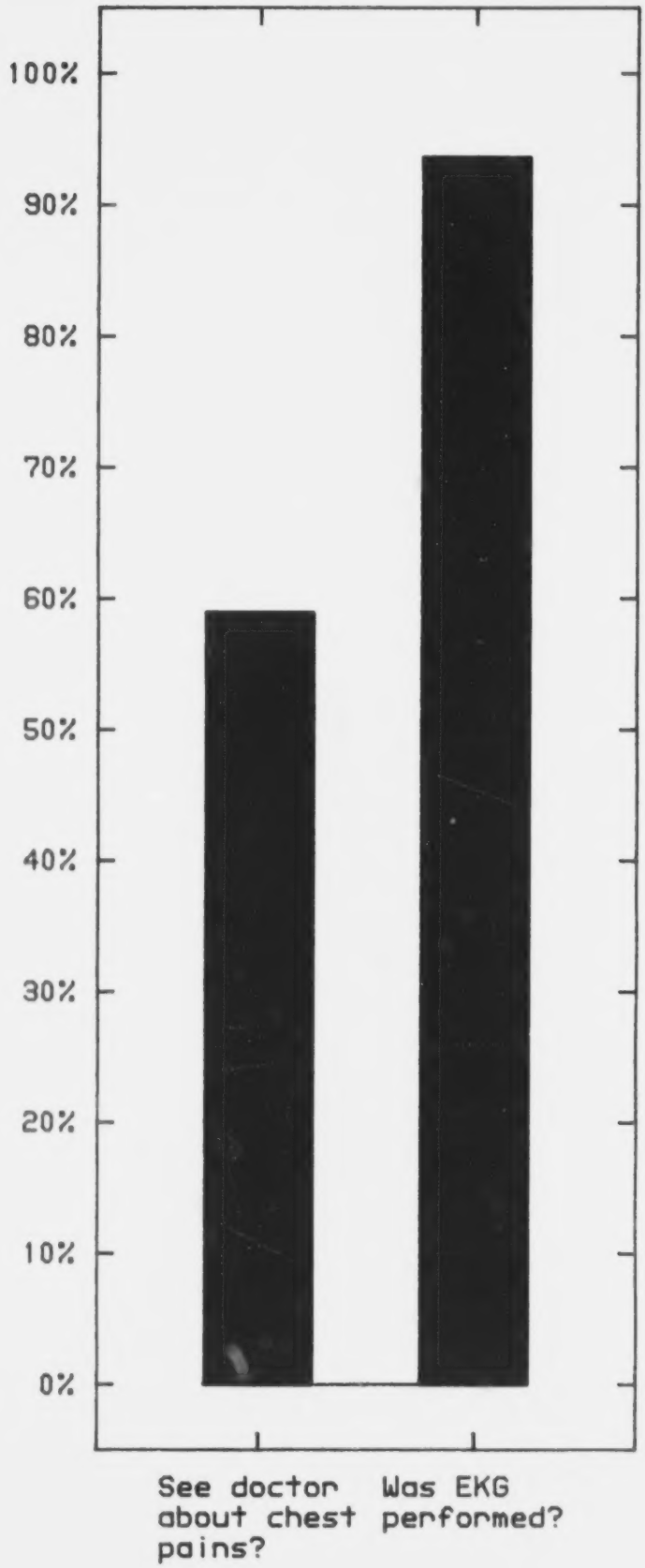
Both sexes reported chest pain. More women reported chest pain than men.



3.17

Responses to Chest Pain

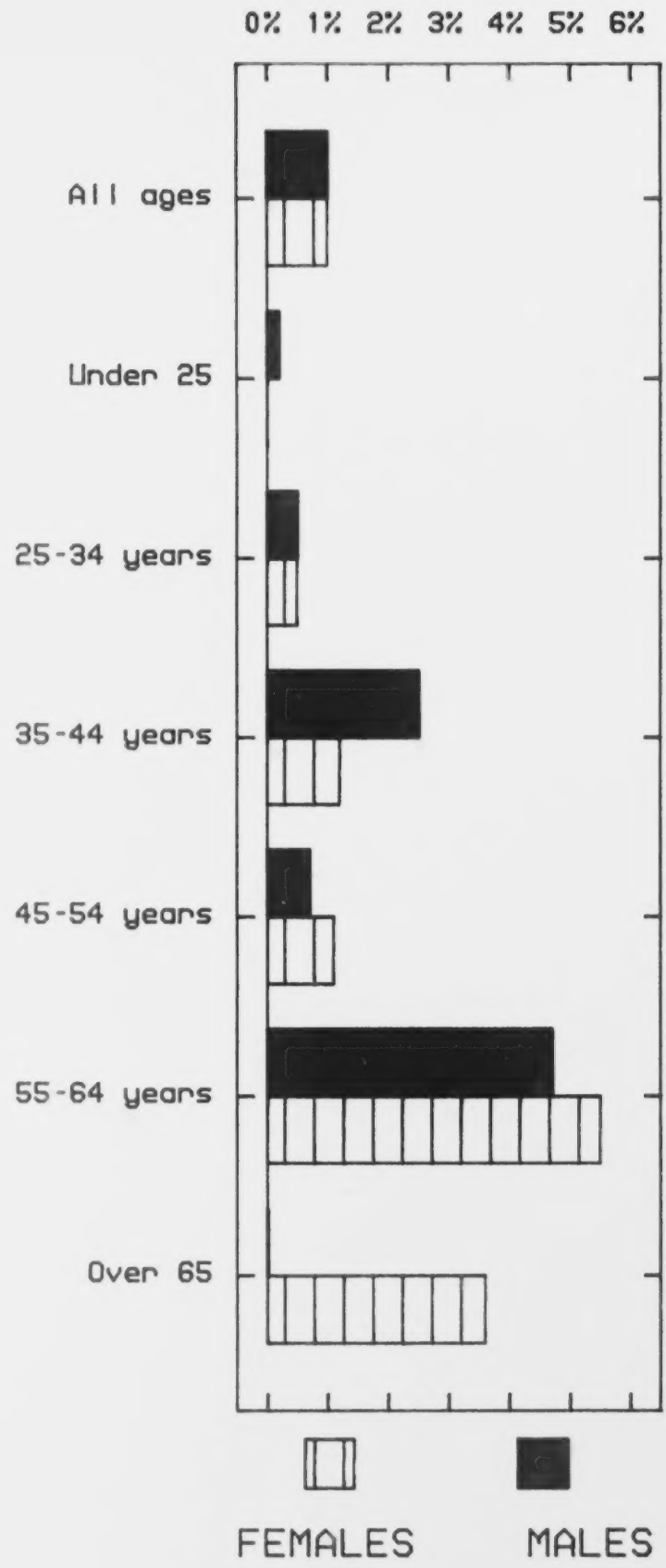
Of those persons reporting chest pain 40% had not seen a physician for the pain. Of those persons who saw a physician for chest pain, 6% did not have an EKG.



3.18

Age-Sex Specific Rates for Diagnosis of Emphysema

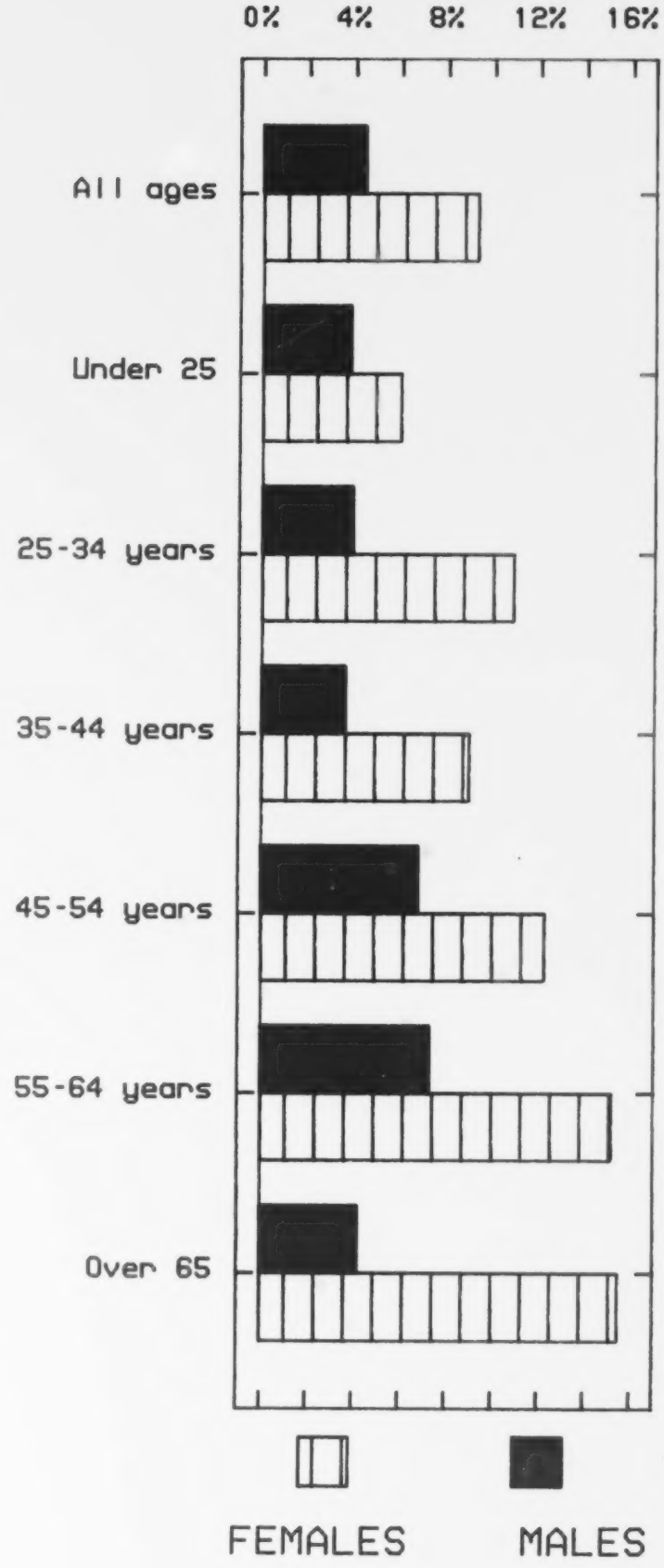
Relatively few individuals had emphysema.



3.19

Age-Sex Specific Rates for Diagnosis of Bronchitis

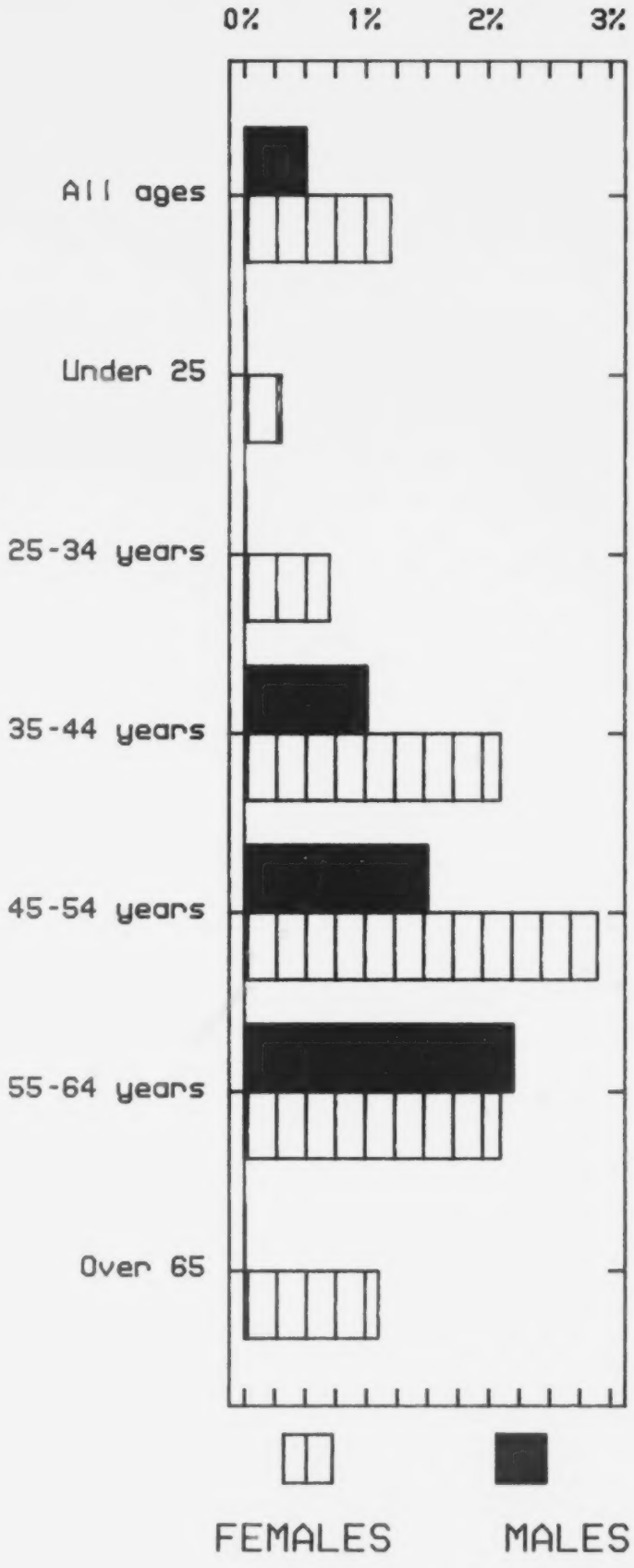
Bronchitis was most common in females.



3.20

Age-Sex Specific Rates for Diagnosis of Rheumatic Heart Disease

Females at all but 55-64 years were more likely to report a history of rheumatic heart disease than males.

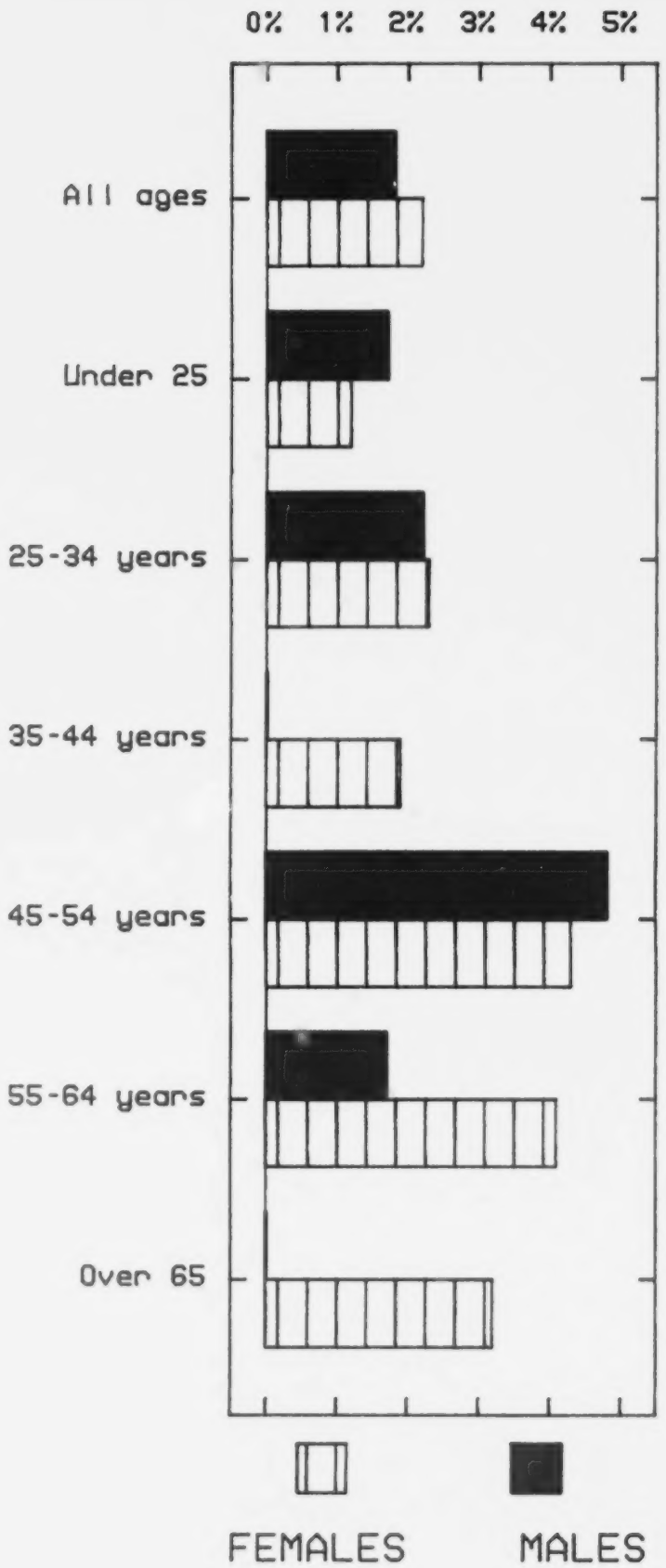


45

3.21

Age-Sex Specific Rates for Diagnosis of Rheumatic Fever

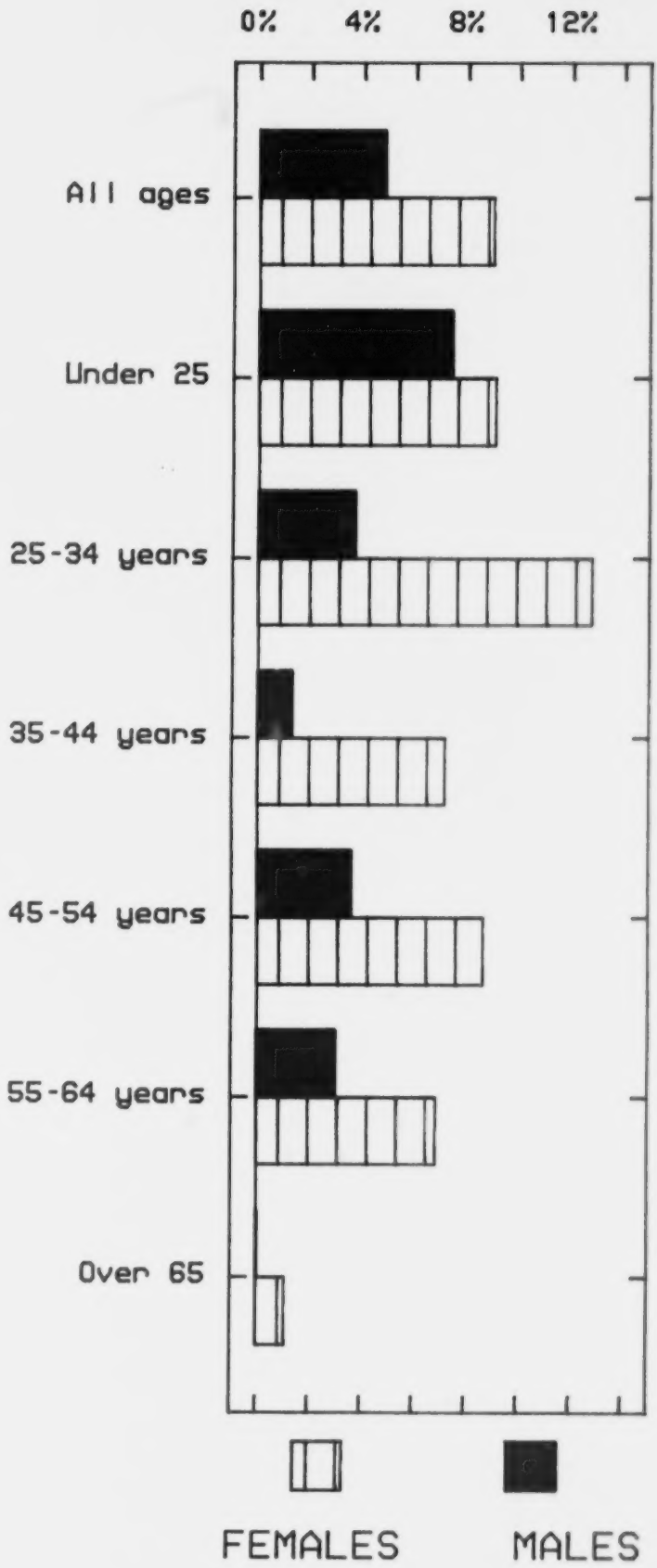
Females had higher rates of rheumatic fever. Especially those over 54 years.



3.22

Age-Sex Specific Rates for Diagnosis of Heart Murmur

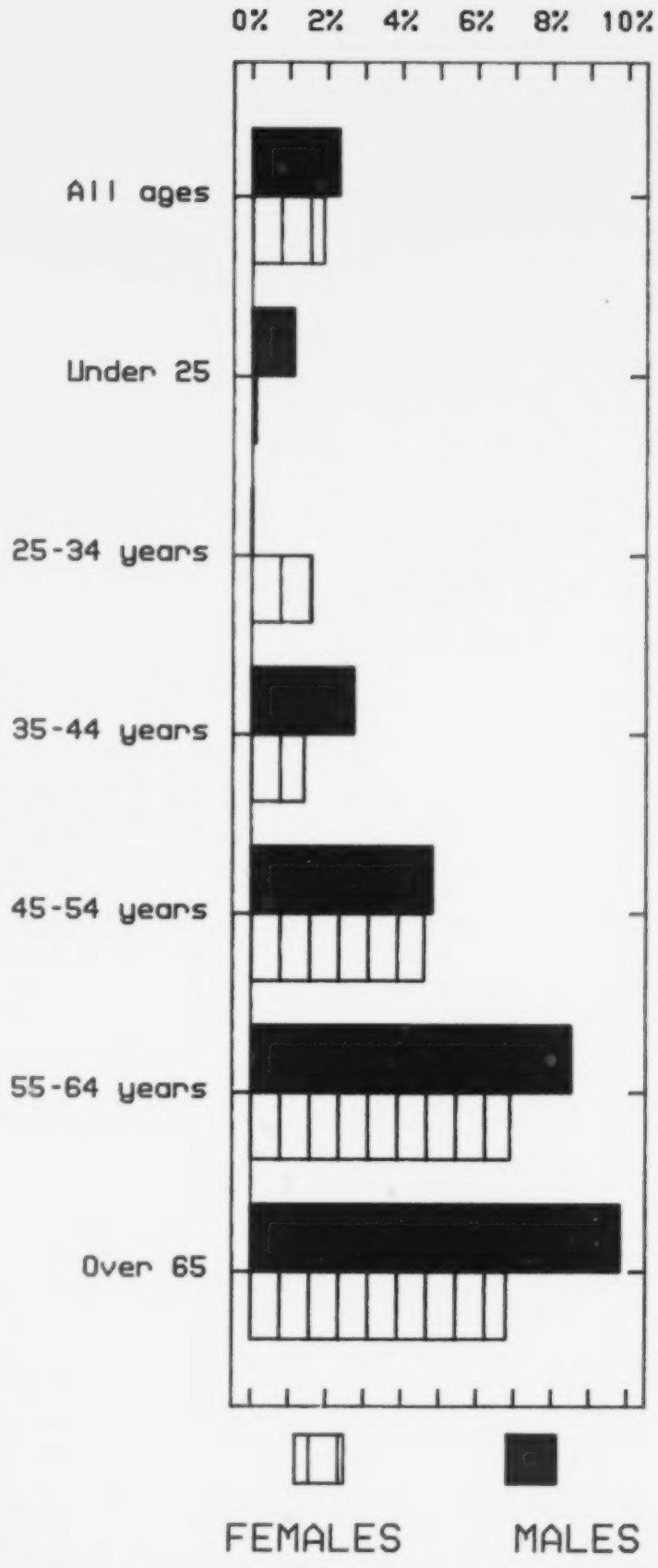
Heart murmur was more common among females. Between ages 25-34 the rates were dramaticaly higher for females.



3.23

Age-Sex Specific Rates for Diagnosis of Heart Failure

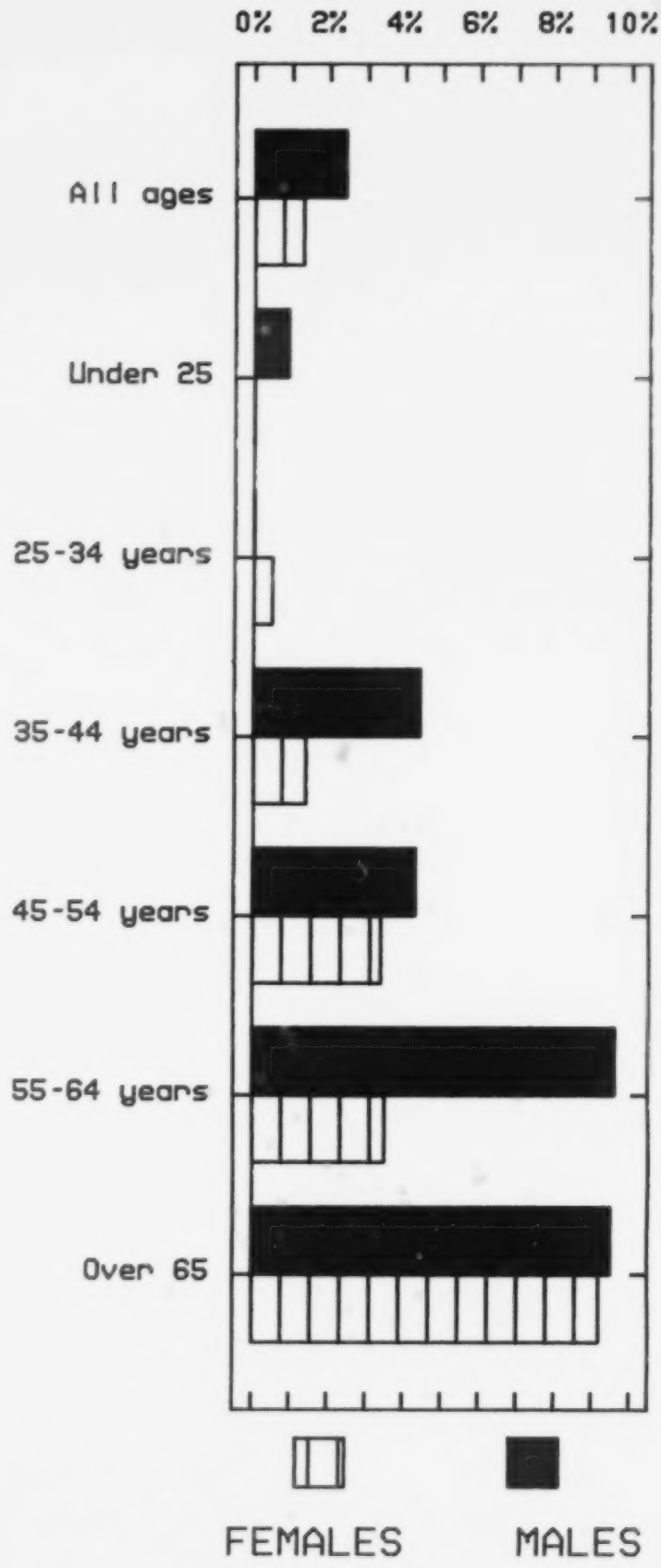
Heart failure rates were low for both sexes until age 45, then increased markedly.



3.24

Age-Sex Specific Rates for Diagnosis of Heart Attack

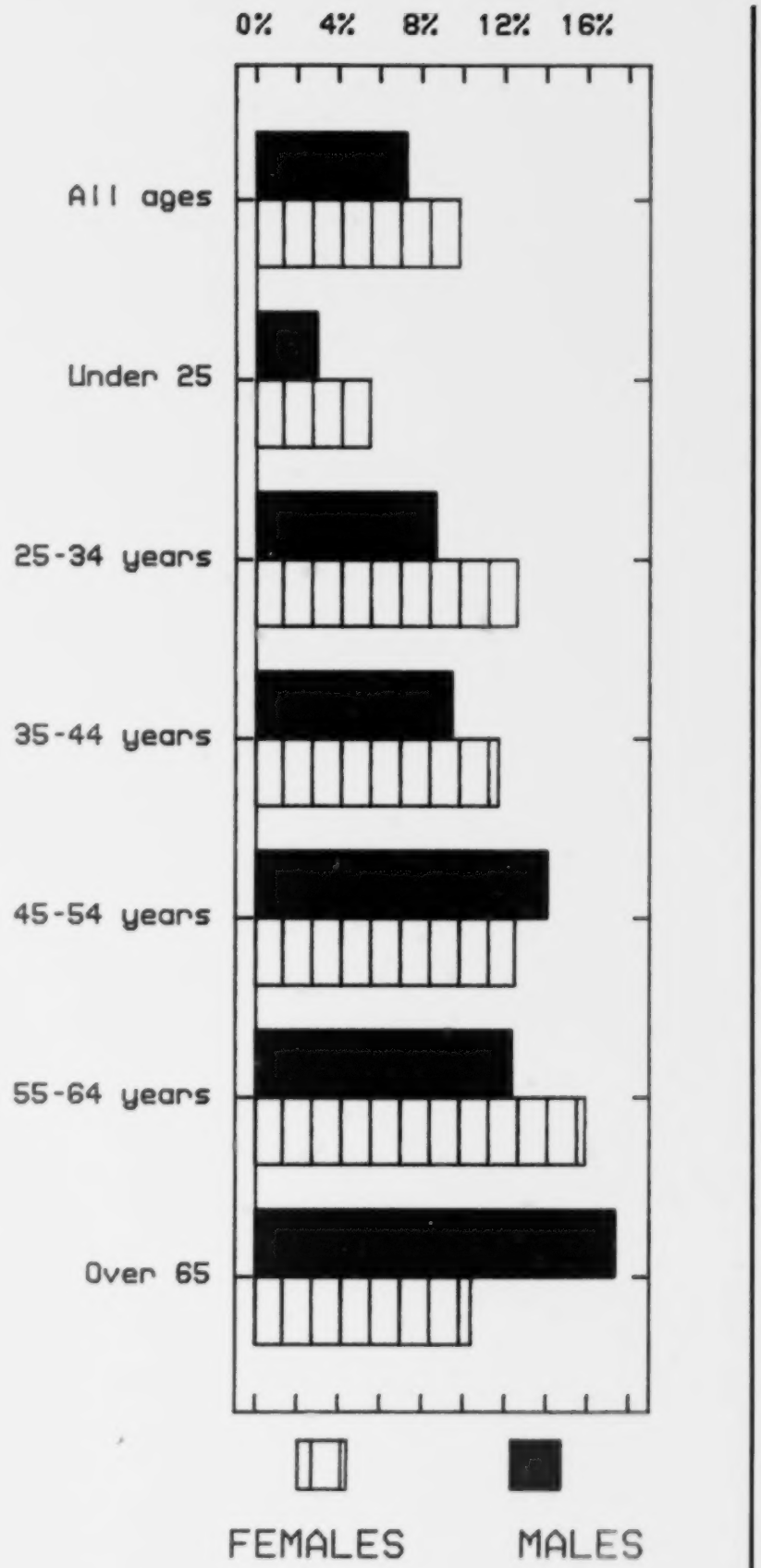
Males had heart attacks more frequently than did females. Except for ages 25-34 years.



3.25

Age-Sex Specific Rates for Diagnosis of Kidney Problems

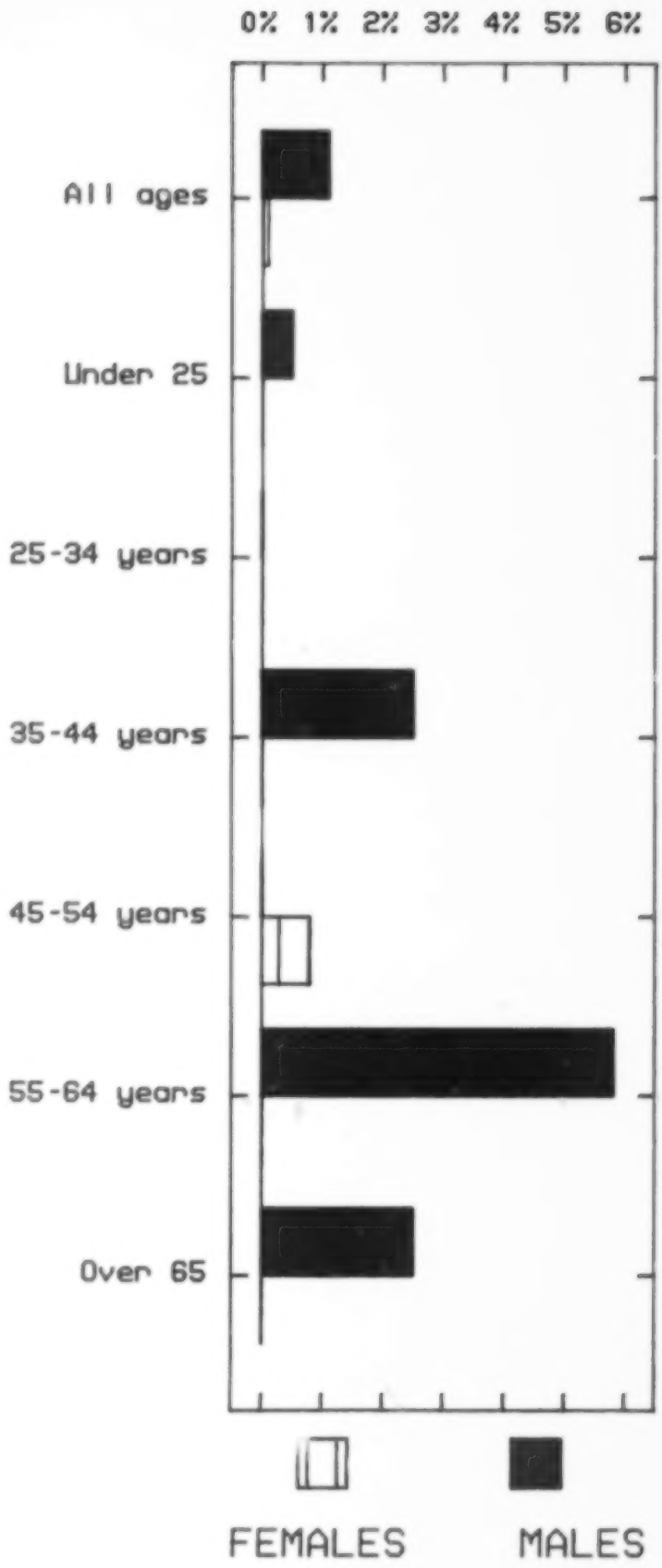
Generally females had kidney disease more often than did males.



3.26

Age-Sex Specific Rates for Diagnosis of Cirrhosis

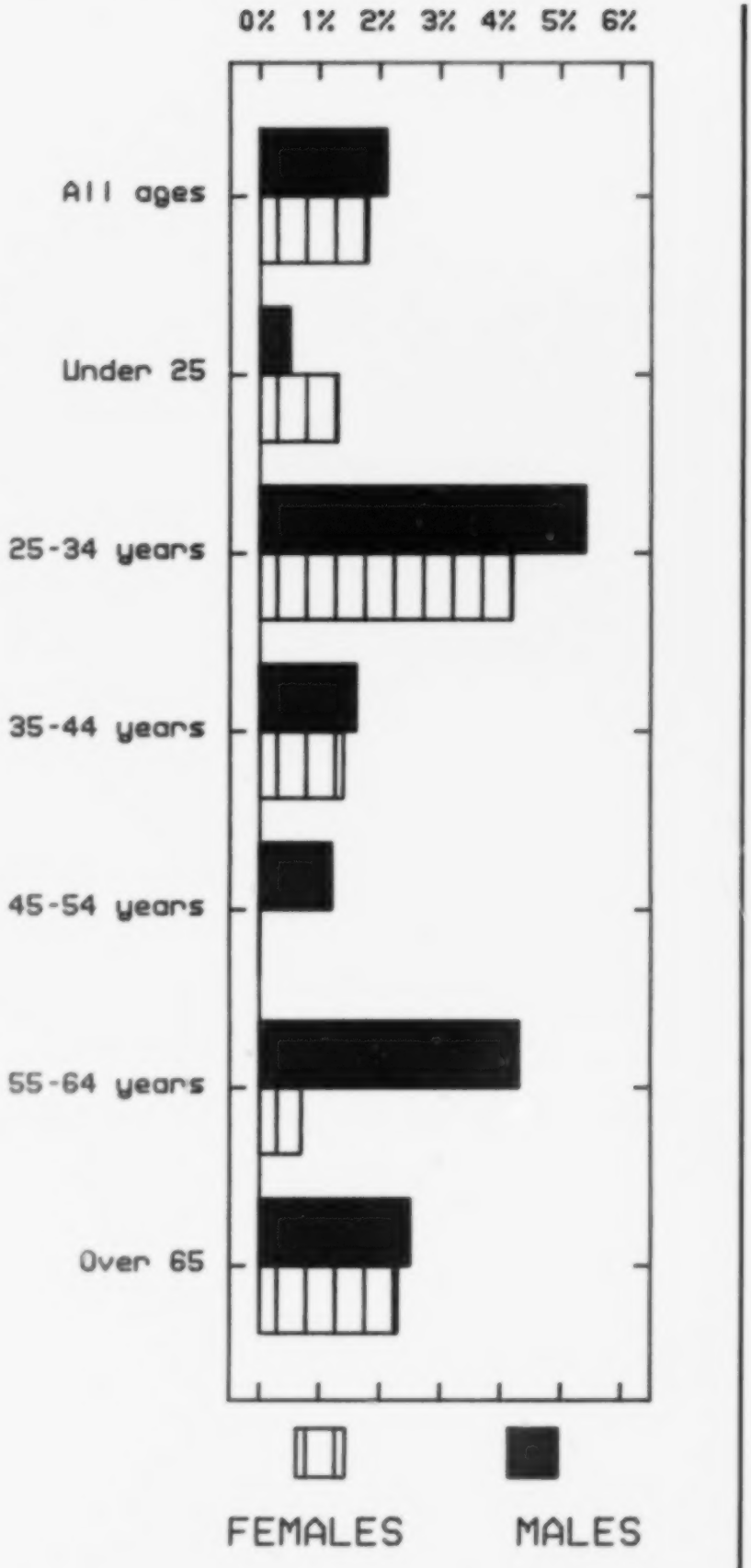
Other than ages 45-54 years females did not report cirrhosis.



3.27

Age-Sex Specific Rates for Diagnosis of Hepatitis

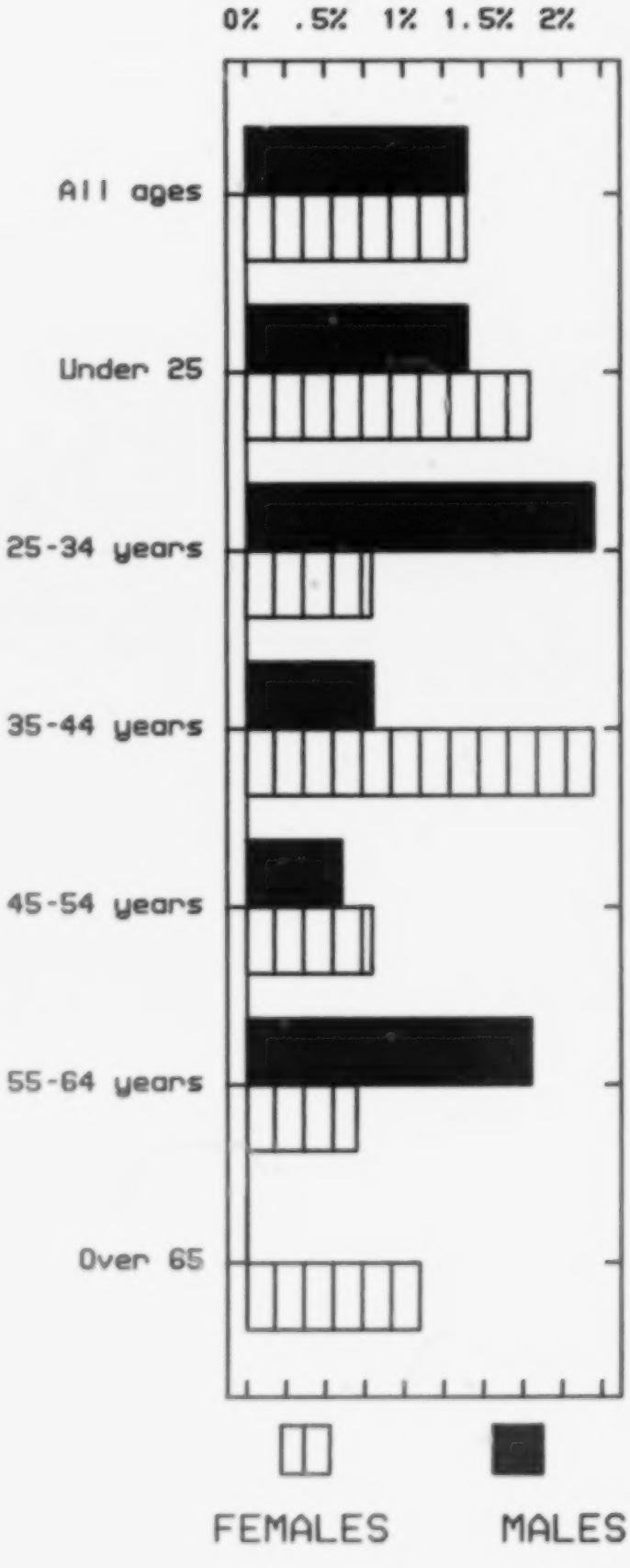
Males appeared to be much more susceptible to hepatitis, except for the under 25 patient.



3.28

Age-Sex Specific Rates for Diagnosis of Yellow Jaundice

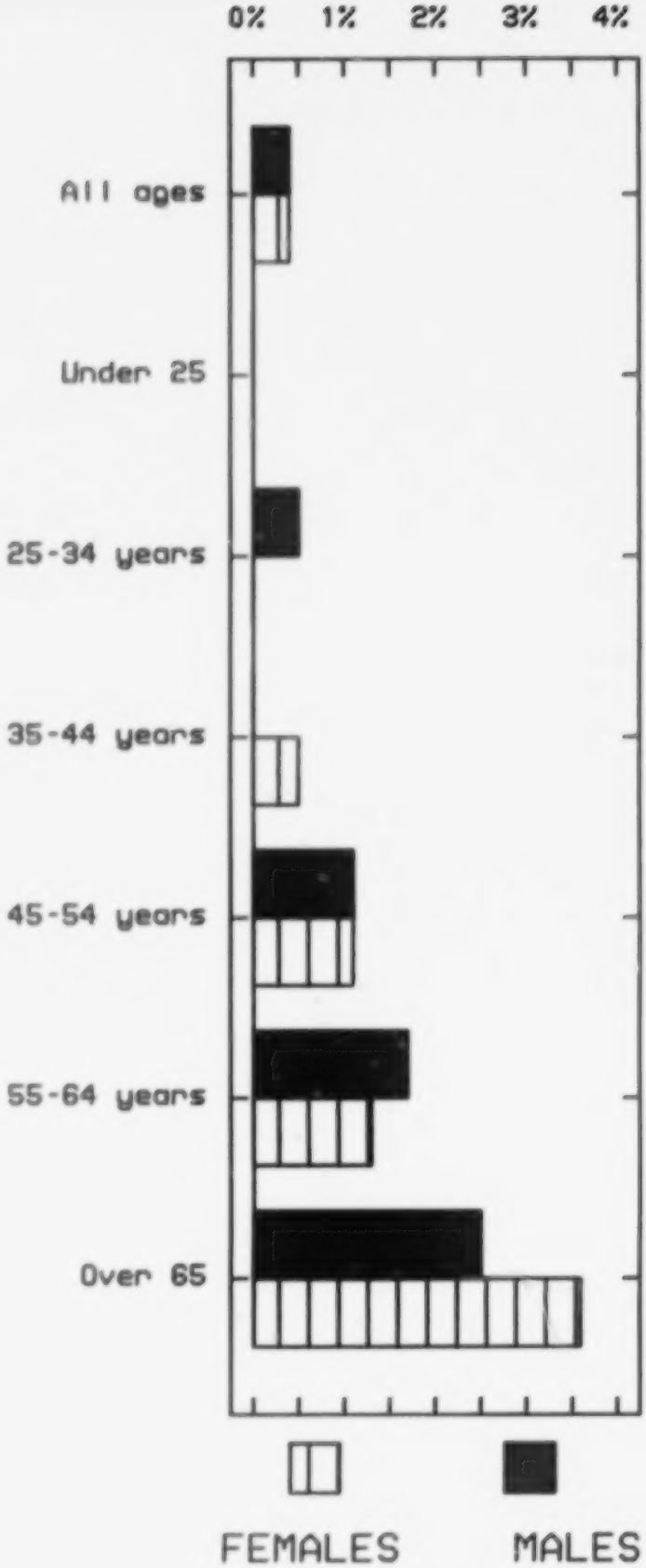
Yellow jaundice rates, overall, were the same for males and females with various differences among the age categories.



3.29

Age-Sex Specific Rates for Diagnosis of Stroke

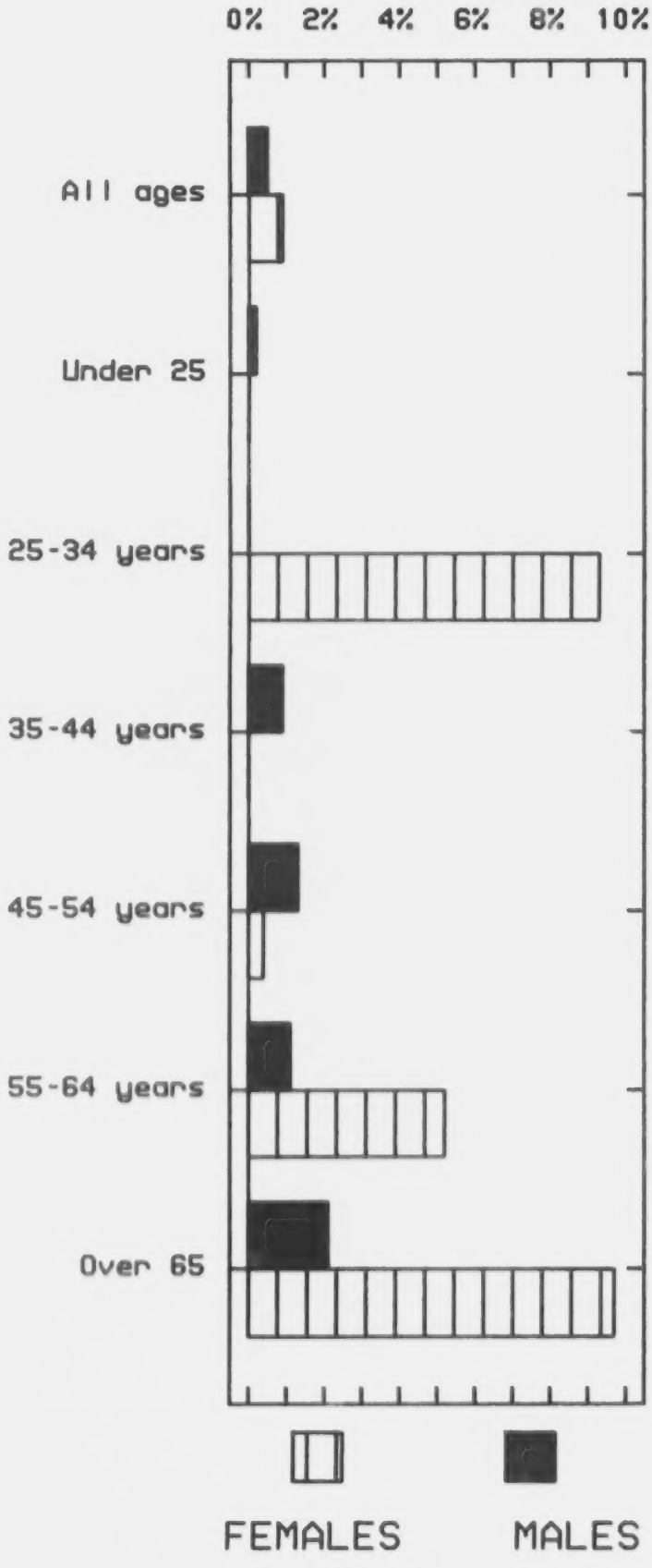
Stroke was very rare, until age 45.



3.30

Age-Sex Specific Rates for Diagnosis of Glaucoma

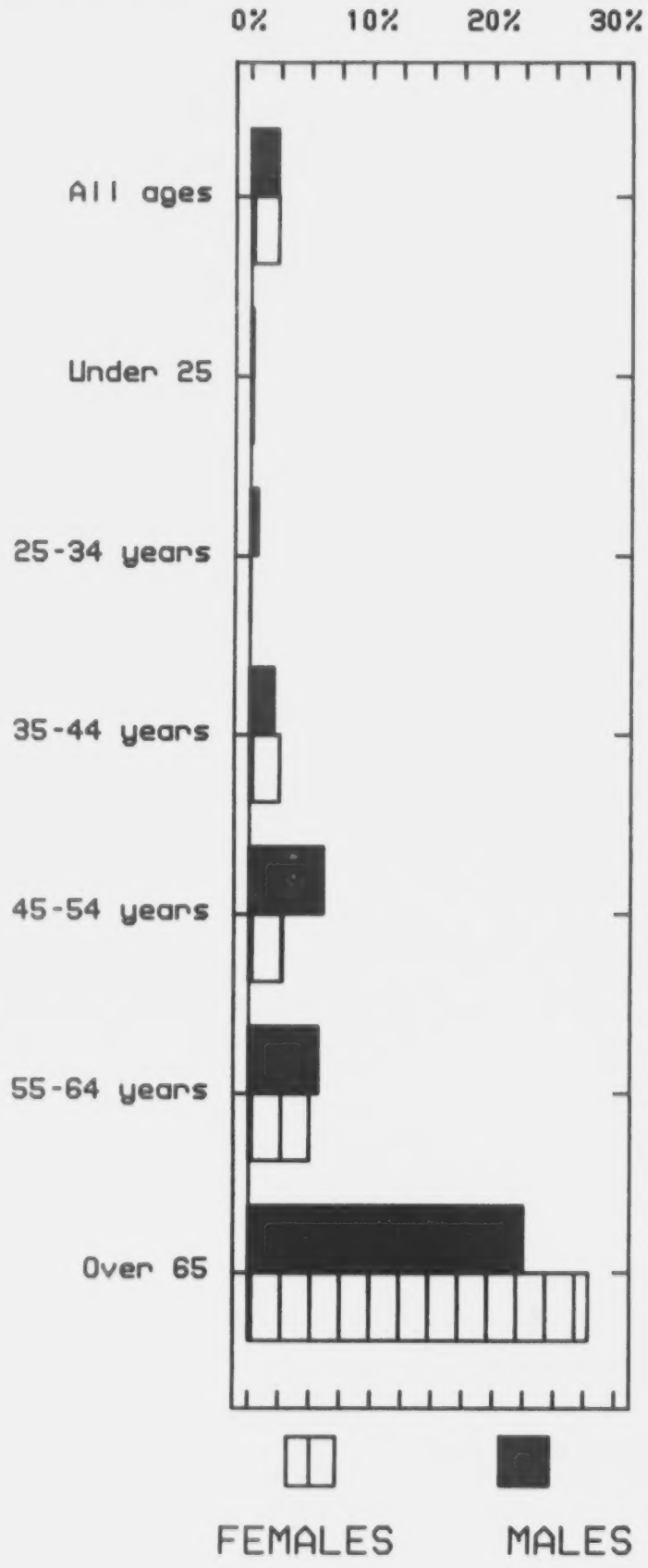
Females were at higher risk for glaucoma.



3.31

Age-Sex Specific Rates for Diagnosis of Cataracts

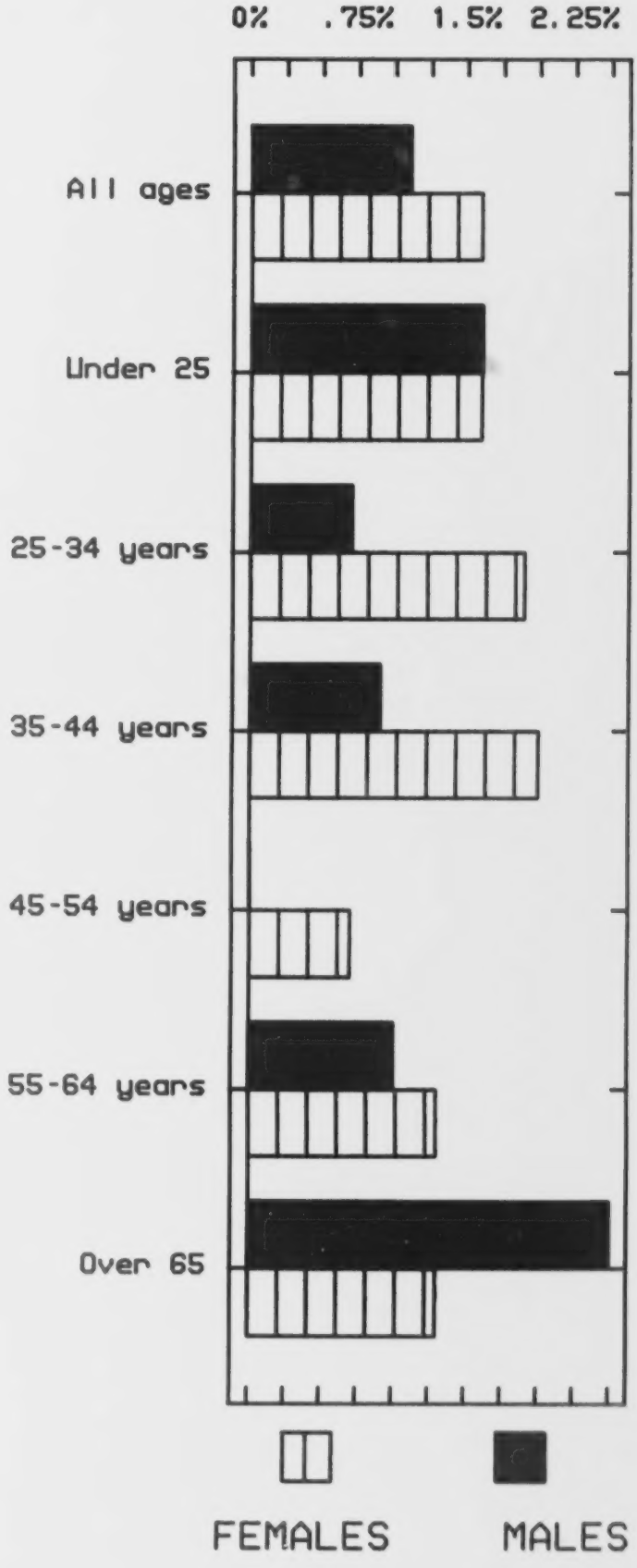
Cataracts, overall, occurred at nearly similar frequencies for both sexes, but there were variations at specific age groupings.



3.32

Age-Sex Specific Rates for Diagnosis of Strabismus

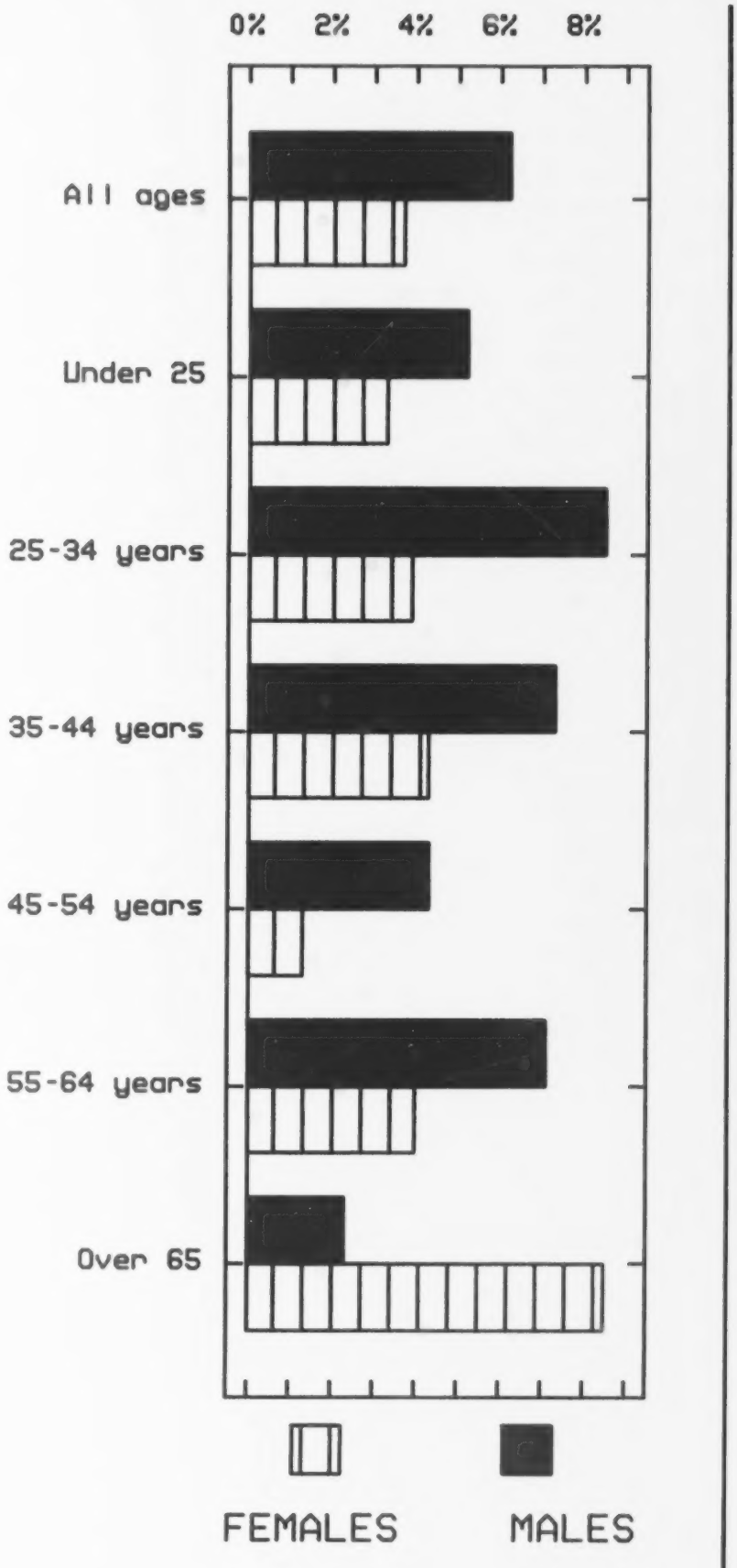
Females had strabismus much more frequently than did males. Except in the over 65 and under 25 categories.



3.33

Age-Sex Specific Rates for Diagnosis of Eye Injury

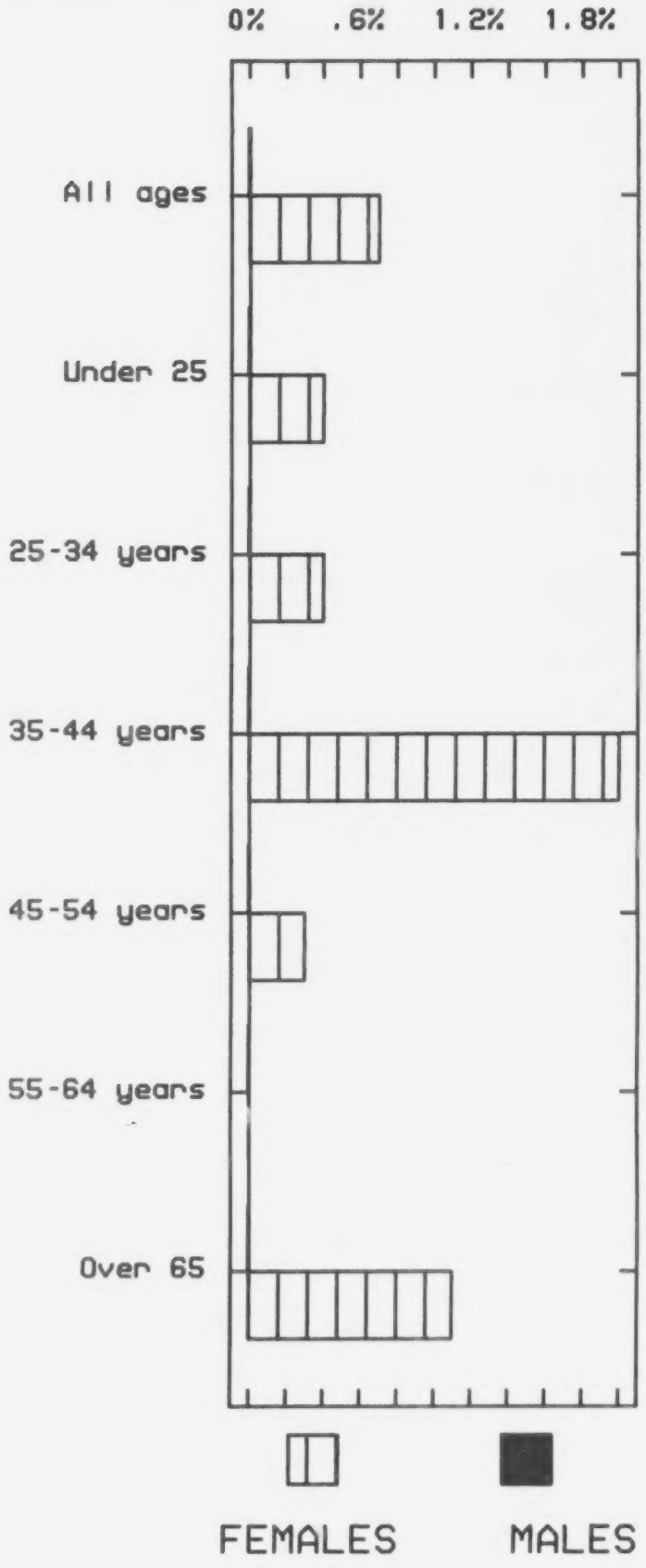
Eye injuries were a more common occurrence among males.



3.34

Age-Sex Specific Rates for Diagnosis of Goiter

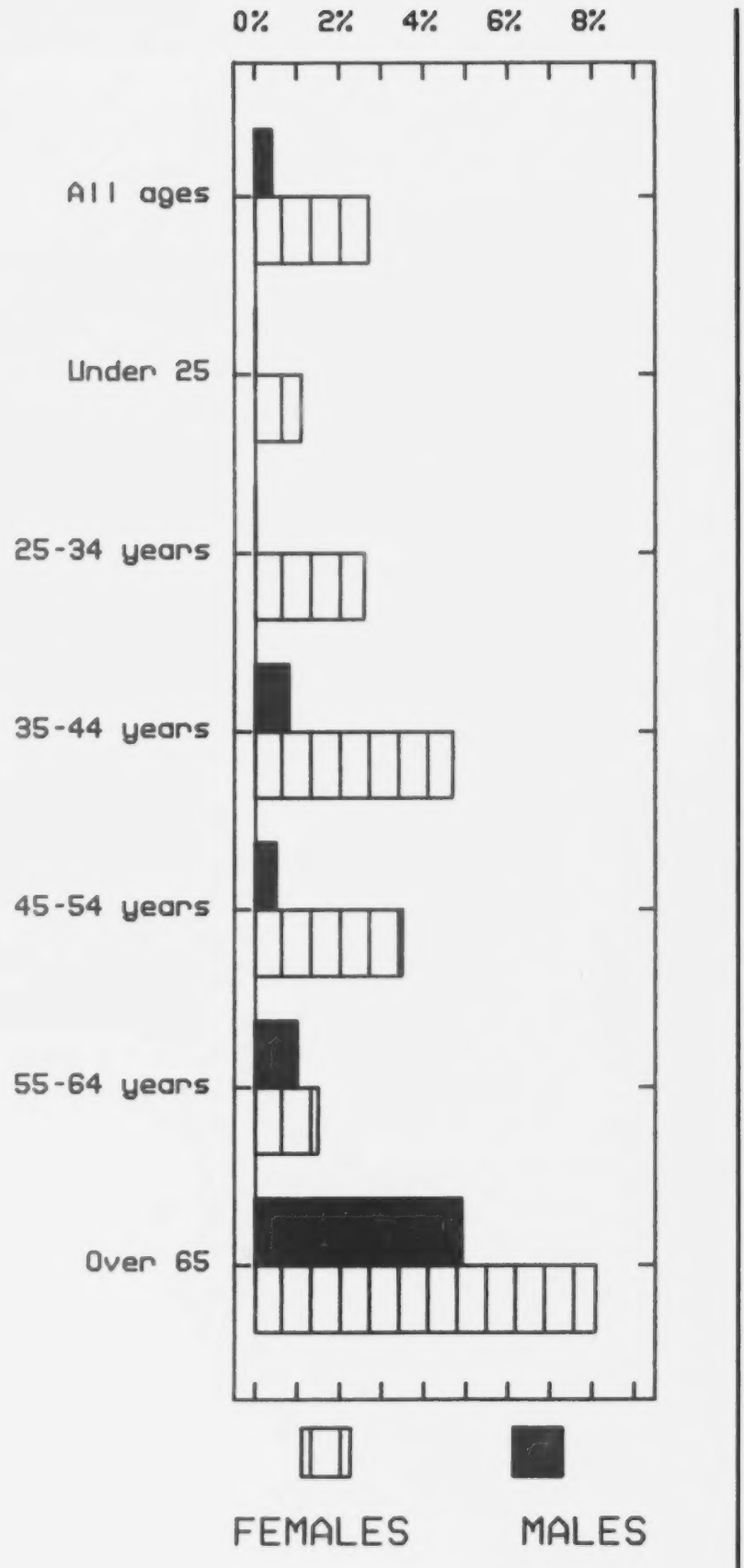
Goiter problems were virtually non-existent for males.



3.35

Age-Sex Specific Rates for Diagnosis of Thyroid Disease

Thyroid disease was more common in females.

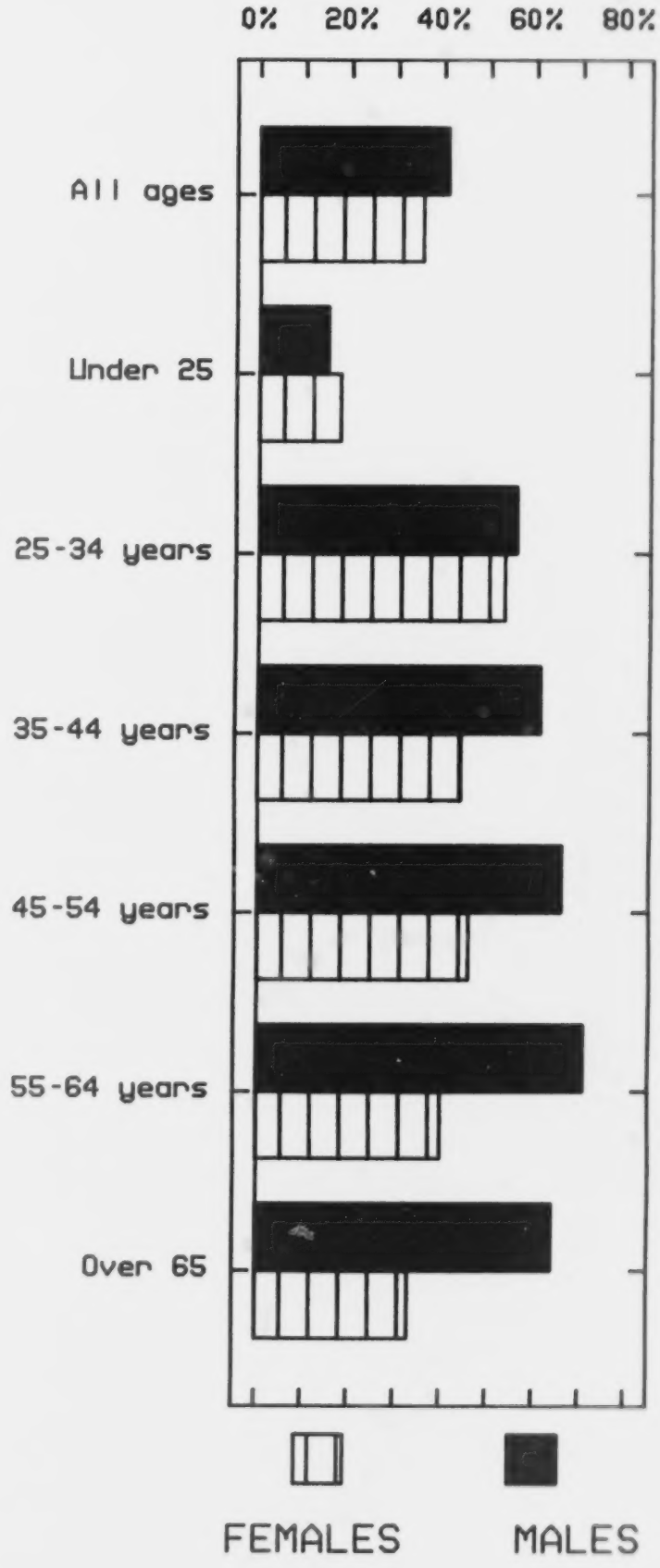


60

3.36

Age-Specific Rates for History of Tobacco Use

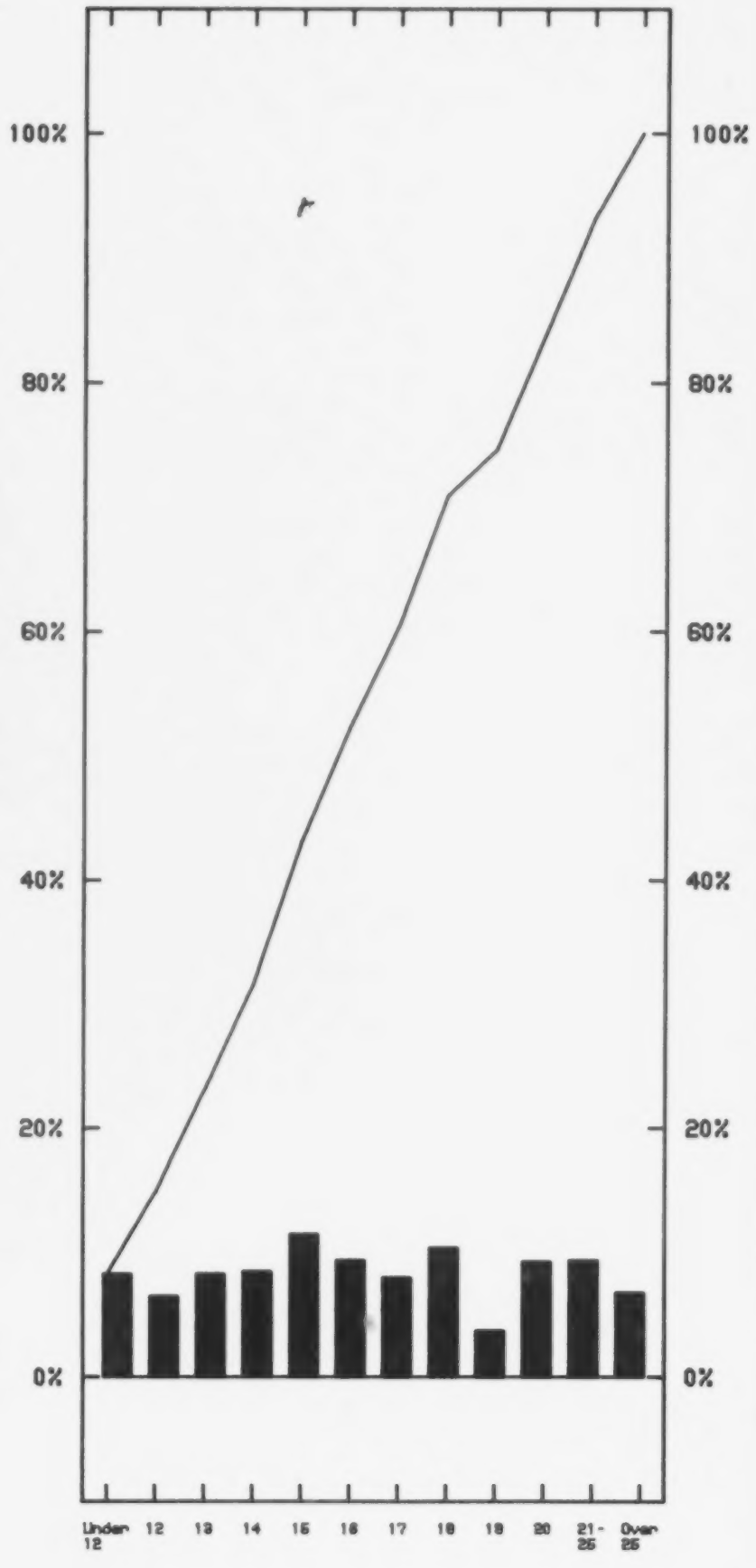
Approximately 35% of adults were or had been smokers. The number of male smokers was much larger than the number of female smokers.



3.37

Age and Cumulative Age at Which Respondent Started Smoking

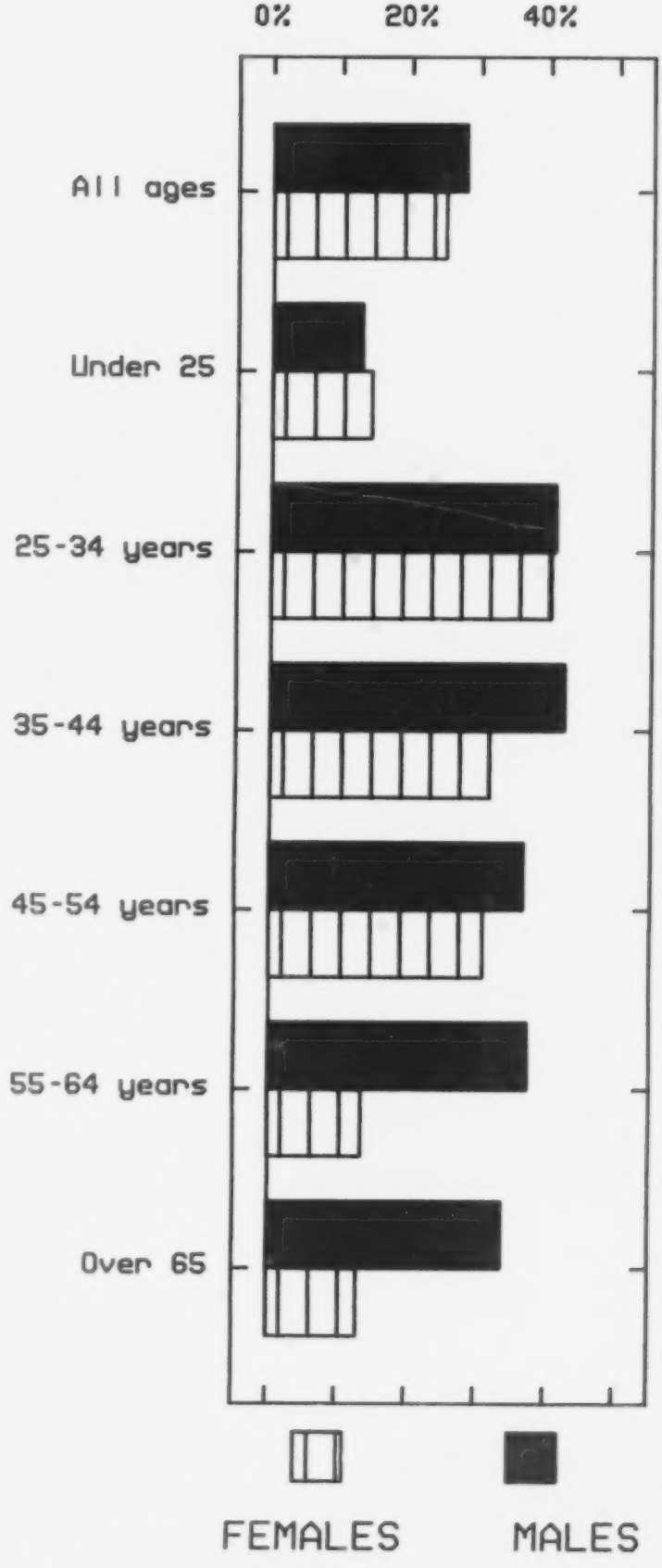
Over 70% of respondents started smoking by age 18. Over 30% started smoking by age 14.



3.38

Age-Sex Specific Rates for Current Tobacco Use

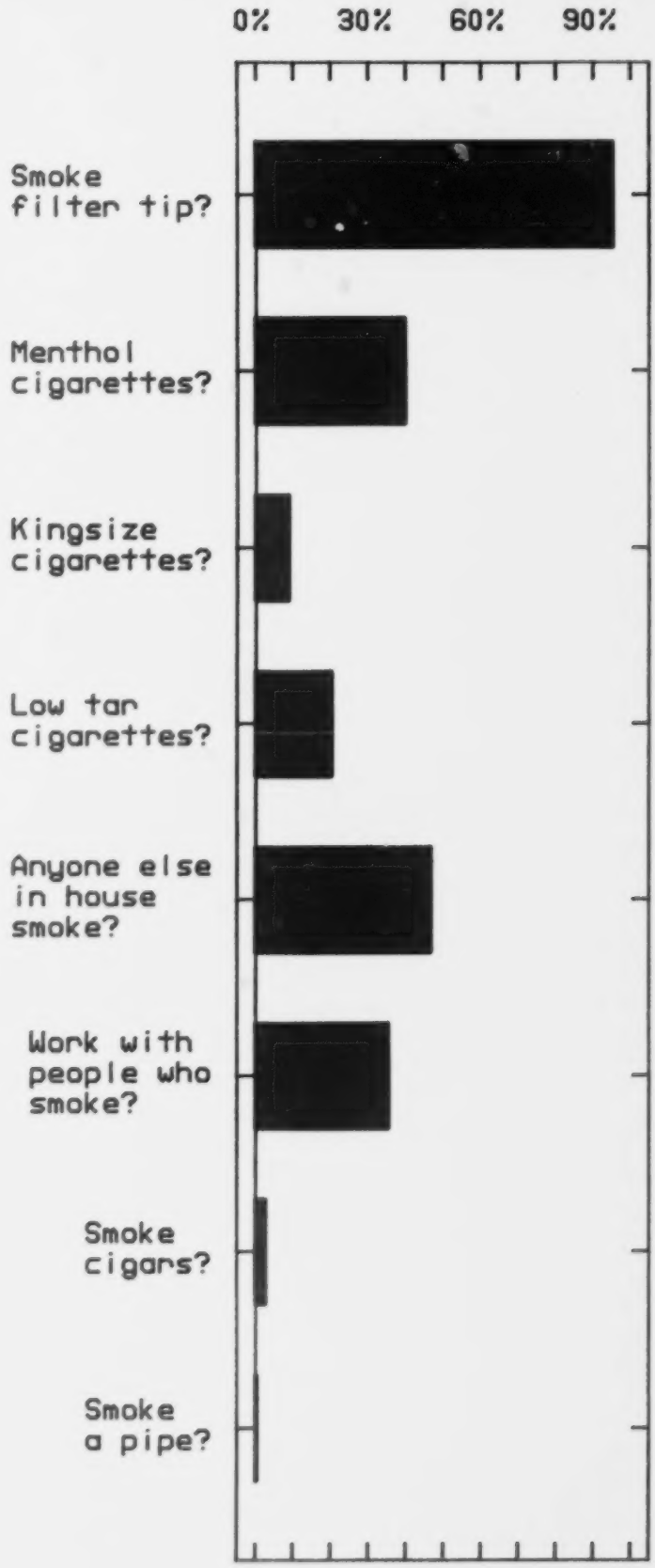
At all age levels above 25 male smokers outnumbered female smokers.



3.39

Aspects of Tobacco Use

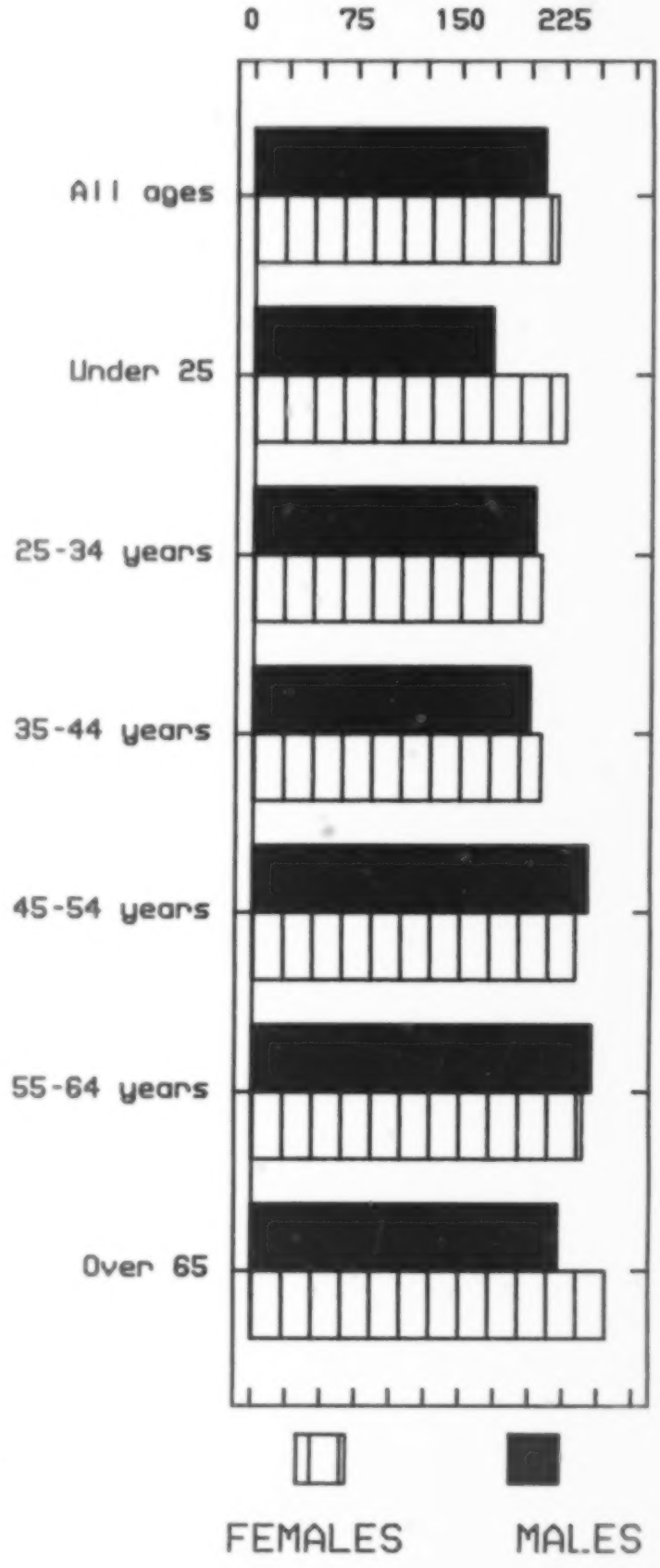
Over 95% of smokers smoked filter tips. Menthol cigarettes were favored by 40% of smokers.



3.40

Age-Sex Specific Mean Serum Cholesterol Levels

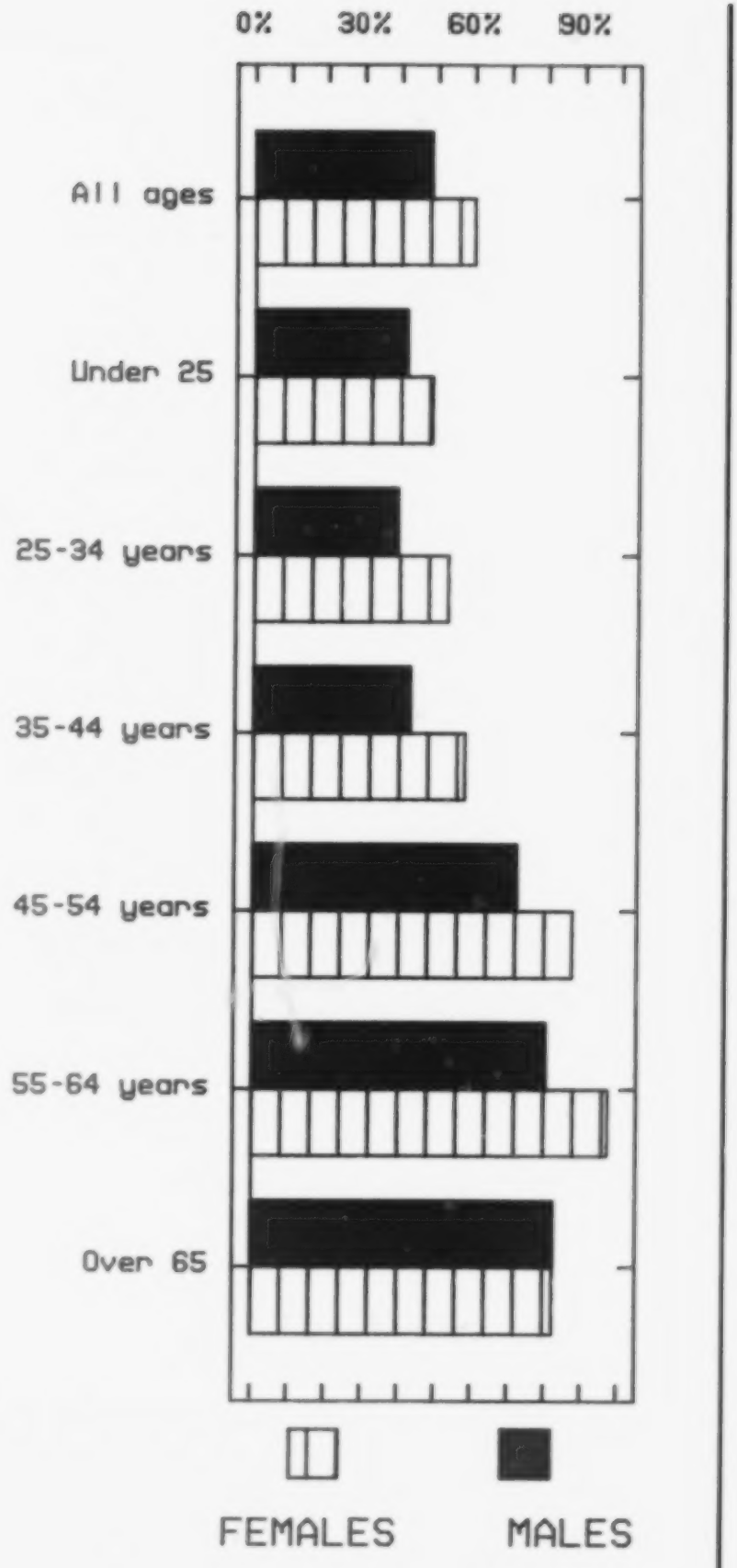
Mean serum cholesterol levels did not vary markedly by age or sex.



3.41

Age-Sex Specific Rates for Vision Impairment

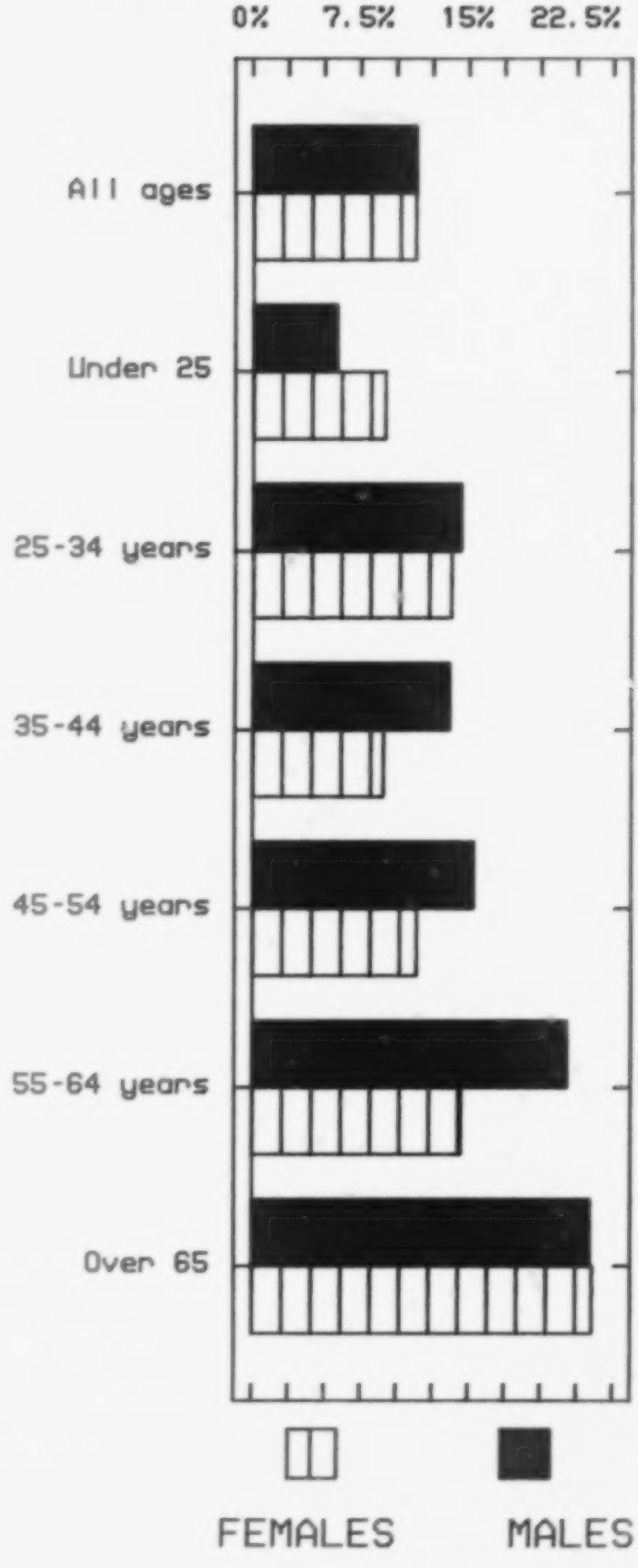
Females were more likely to have vision impairment.



3.42

Age-Sex Specific Rates for Hearing Impairment

Overall hearing impairment was equally distributed. The males had the impairments later in life.



CHAPTER 4

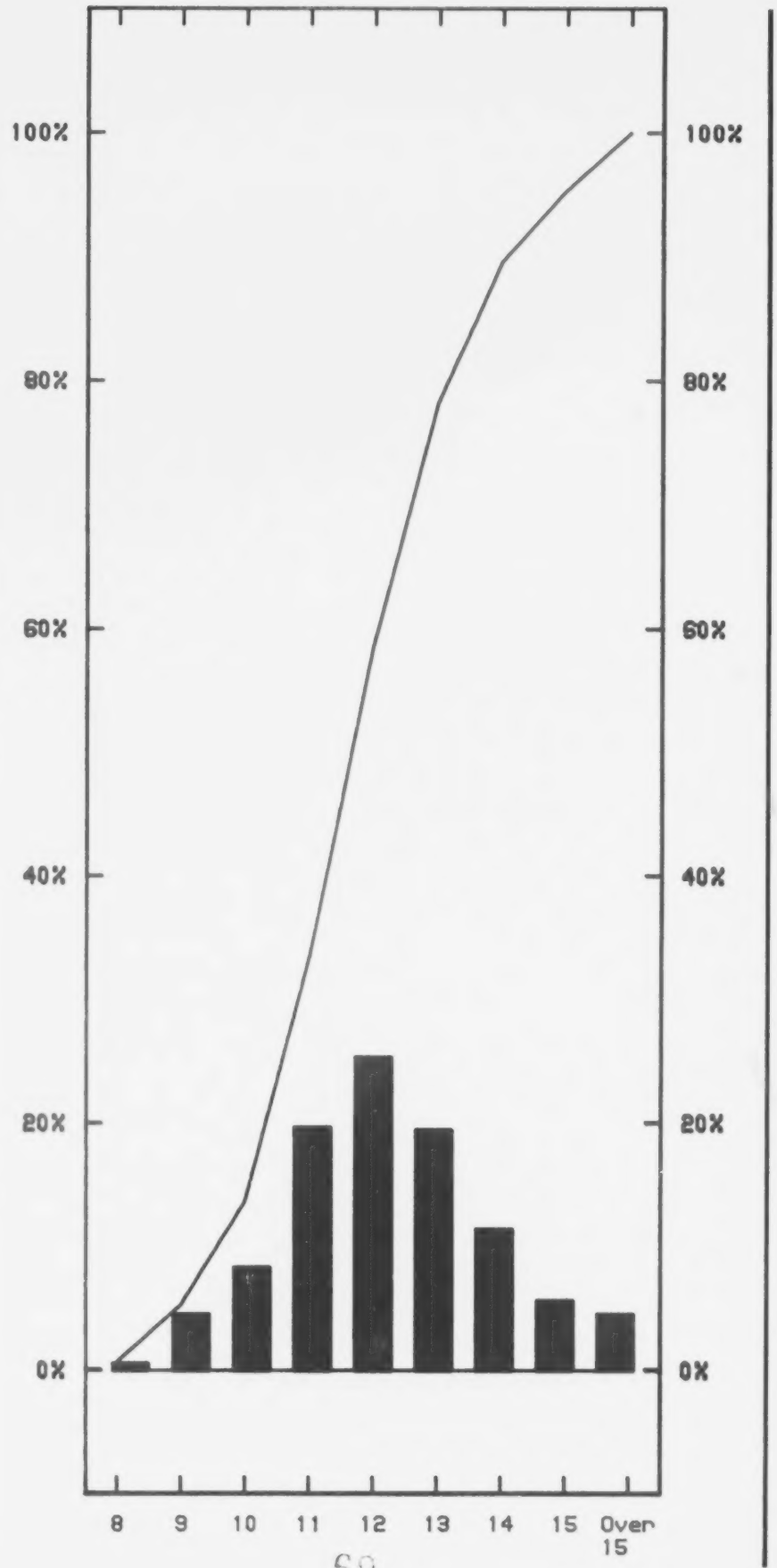
Reproduction and Fertility Factors

The extent to which birth control practices are utilized will prove interesting to many of the readers of this document. Somewhat startling is the failure to follow generally accepted standards for primary prevention regarding two common female illnesses. This omission, however, is apparent among males and females in other areas of health care practices. The number of respondents who have used birth control pills and the number who have had a tubal ligation may come as a surprise to some persons.

4.1

Age and Cumulative Age and Menarche

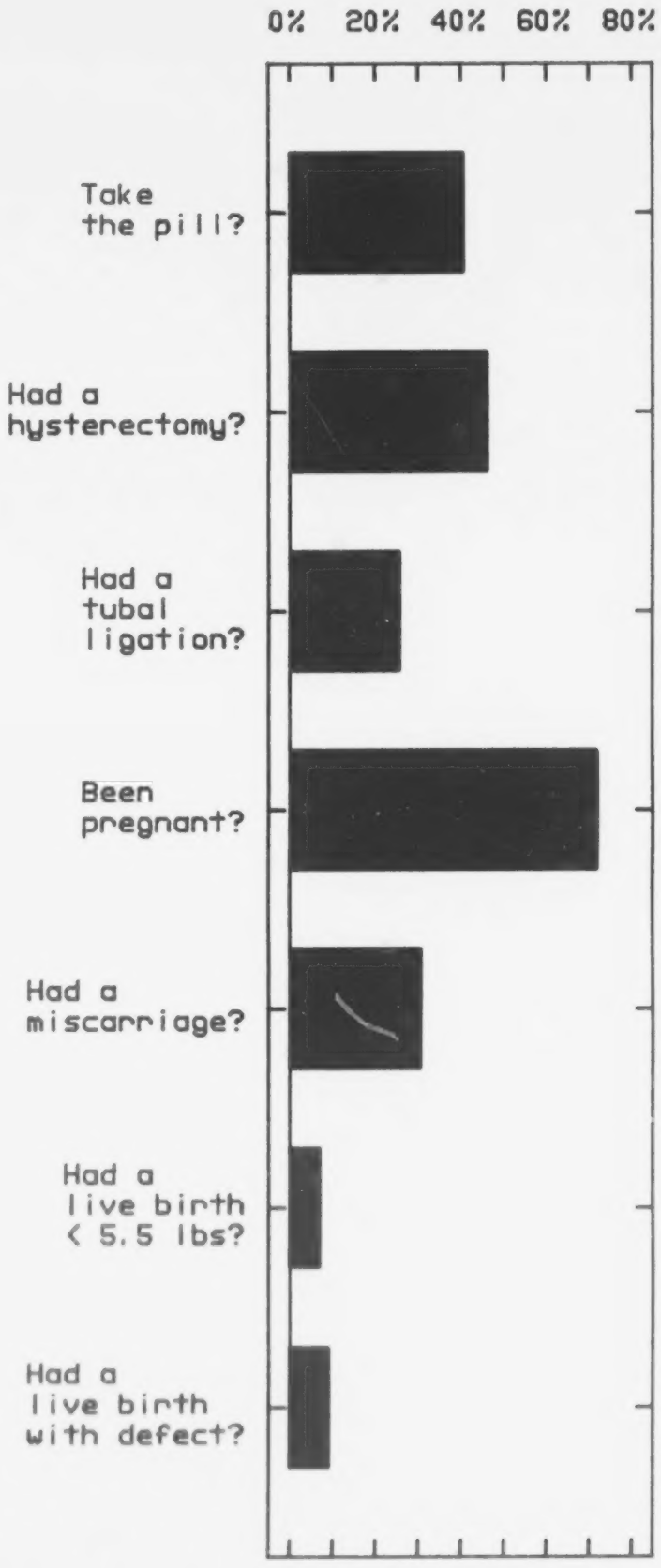
By age 13 approximately 78% of respondents had begun menarche.



4.2

Aspects of Fertility

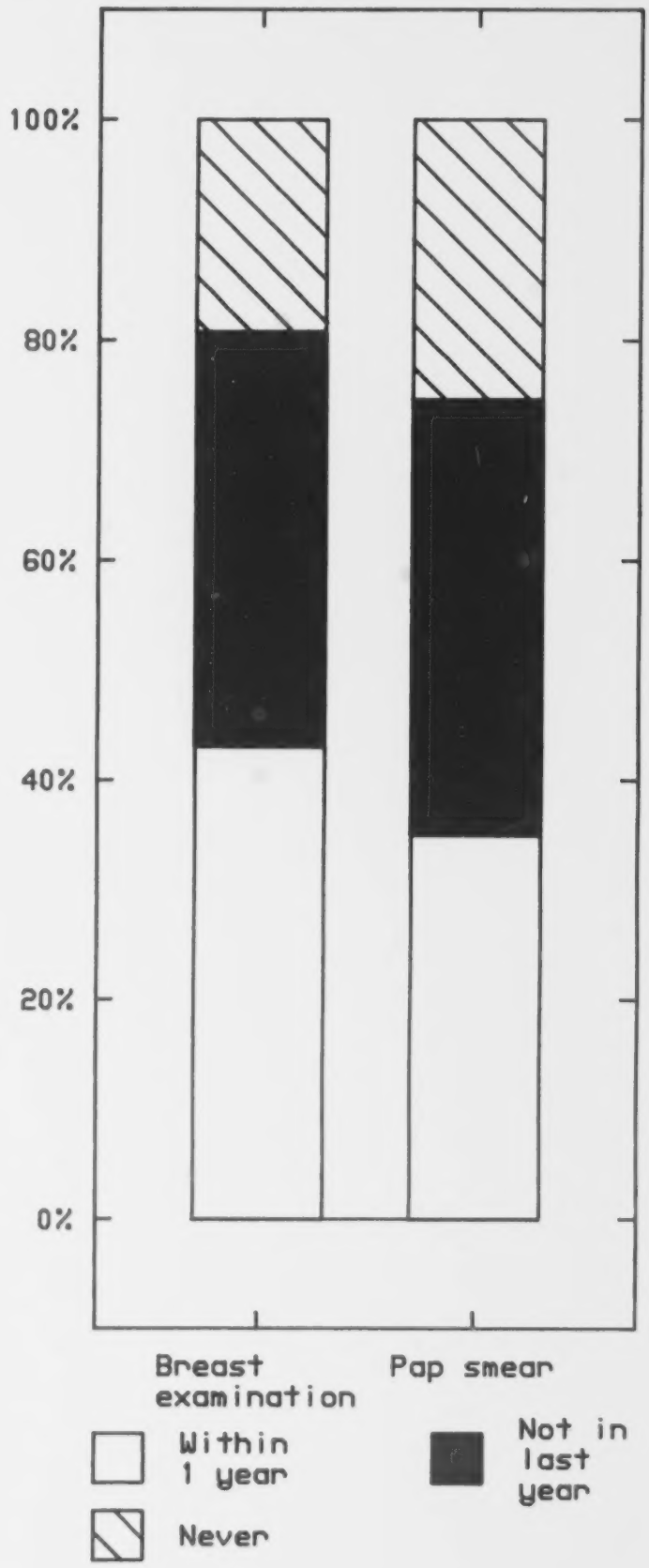
Over 40% of respondents had taken birth control pills. About 25% have had a tubal ligation. Over 70% have been pregnant.



4.3

Time Since Last Pap Smear and Breast Examination

Approximately 20% of respondents had never had their breasts examined by a health professional. About 25% had never had a pap smear.



CHAPTER 5

Health Care Utilization

In 1983, family income for minorities was positively related to the frequency of physician and dental visits, but negatively related to the number of hospital discharges and the length of hospital stay. In 1978, an estimated 30 million people were without a regular source of medical care, and approximately half indicated "no doctor needed" as the primary reason.

Between 1976 and 1981, the annual number of visits to a physician's office decreased slightly from 2.78 to 2.59 according to data from the National Ambulatory Medical Care Survey.

The Hispanic Health and Nutrition Examination Survey indicated that 53% of the Puerto Rican respondents reported that their usual source of health care was a private physician or clinic, 5% utilized an outpatient clinic and 7% a Community Health Center.

Puerto Rican indicated that of the factors effecting their non-use of health care, the two most frequently noted were cost and long periods of waiting.

It is important to note that 6% of Puerto Ricans have never had a routine physical examination and 32% had an examination five years ago. Also, 1½% were never examined by a dentist, and 10½% had not seen one within the last five years.

Puerto Rican females were admitted more frequently to a hospital than males.

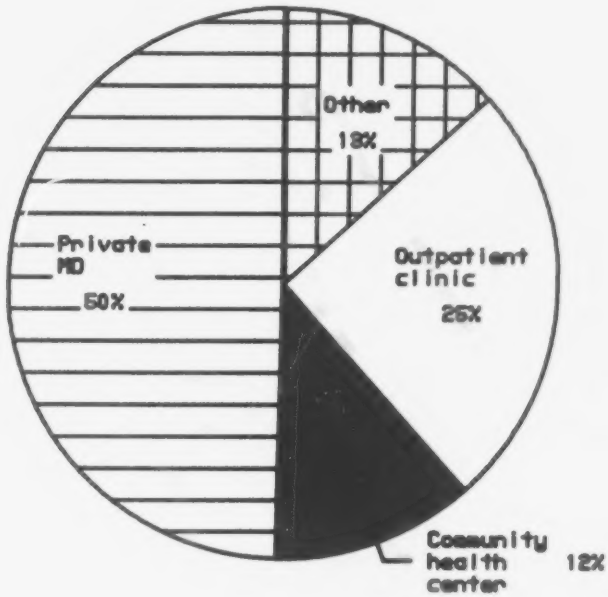
5.1

Health Care Utilization 1

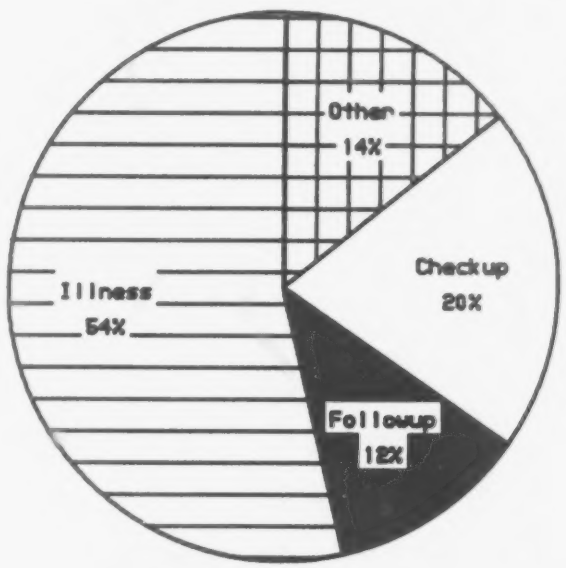
a.
Seventy-five percent reported that their usual source of health care was a private physician or clinic.

b.
Approximately 54% of respondents reported that the purpose of their most recent visit to their usual source of health care was due to some illness.

Type of Usual Source of Health Care



Reason for Last Visit for Health Care



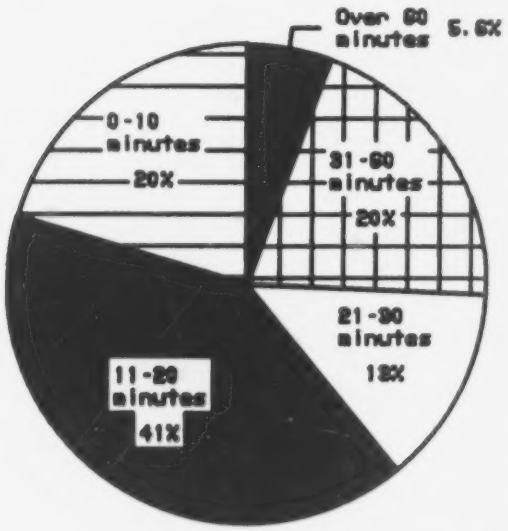
5.2

Health Care Utilization II

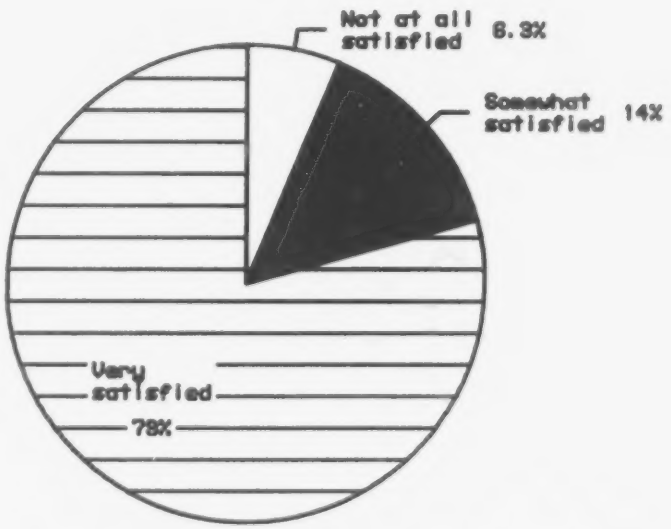
a.
About 74% of respondents indicated that it took thirty minutes or less to get to their usual place of health care.

b.
About 80% were very satisfied with their health care.

Time to get to
Usual Source of Health Care



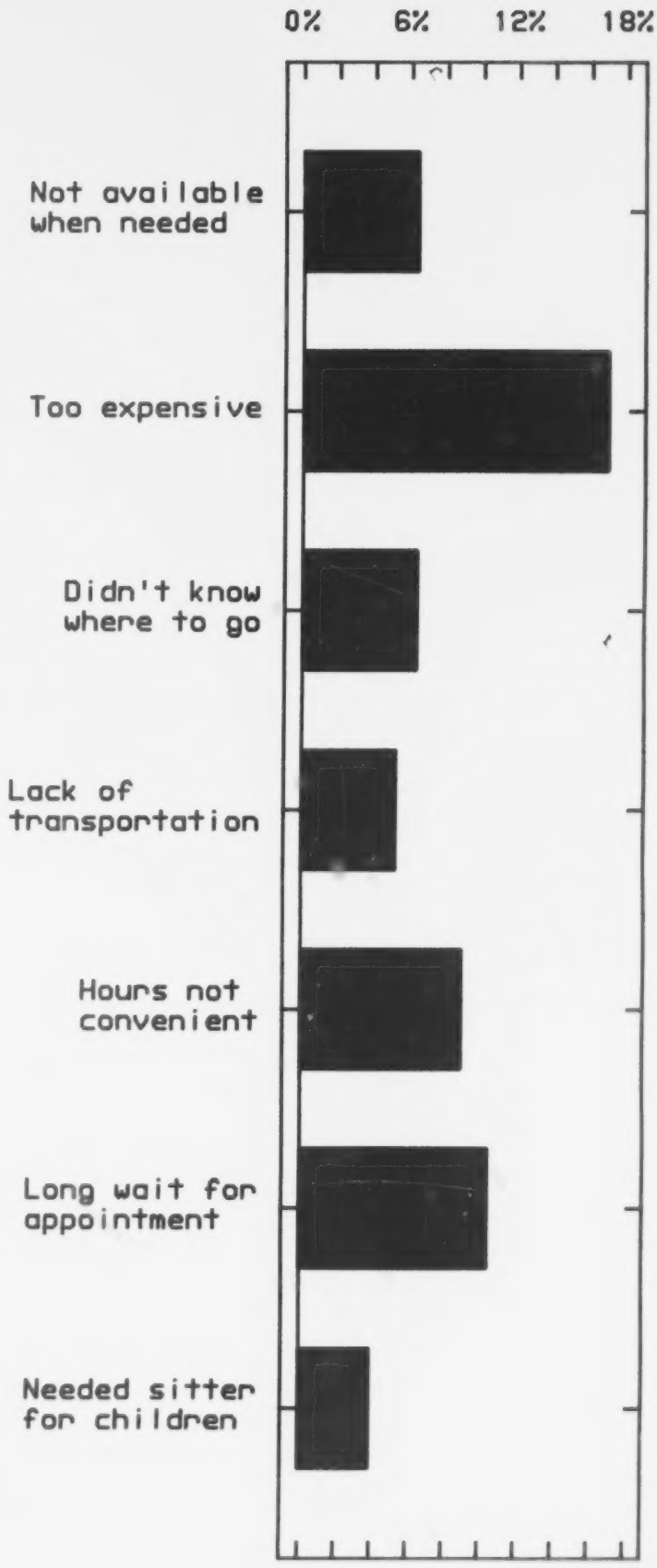
Satisfaction with Last Visit
to Usual Source of Health Care



5.3

Health Care Access Factors I

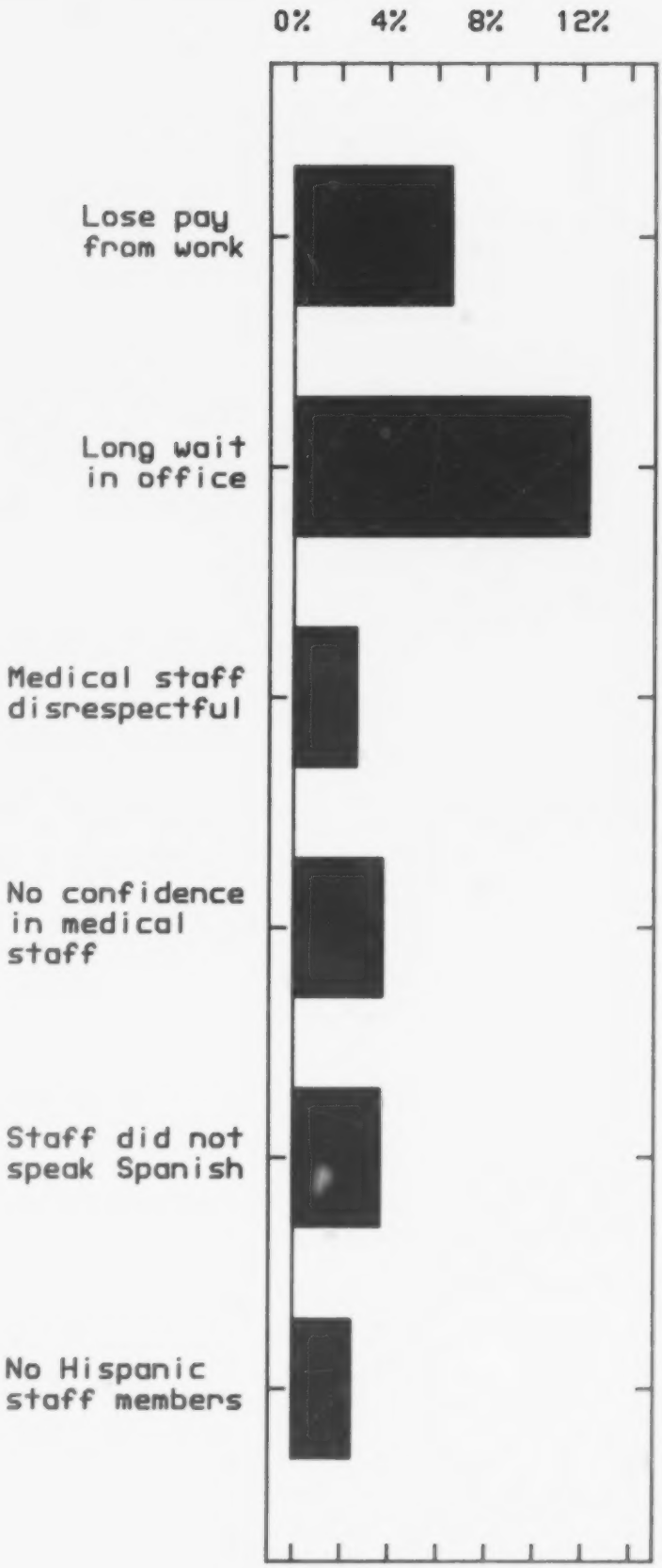
Cost was the major factor of dissatisfaction with health care.



5.4

Health Care Access Factors II

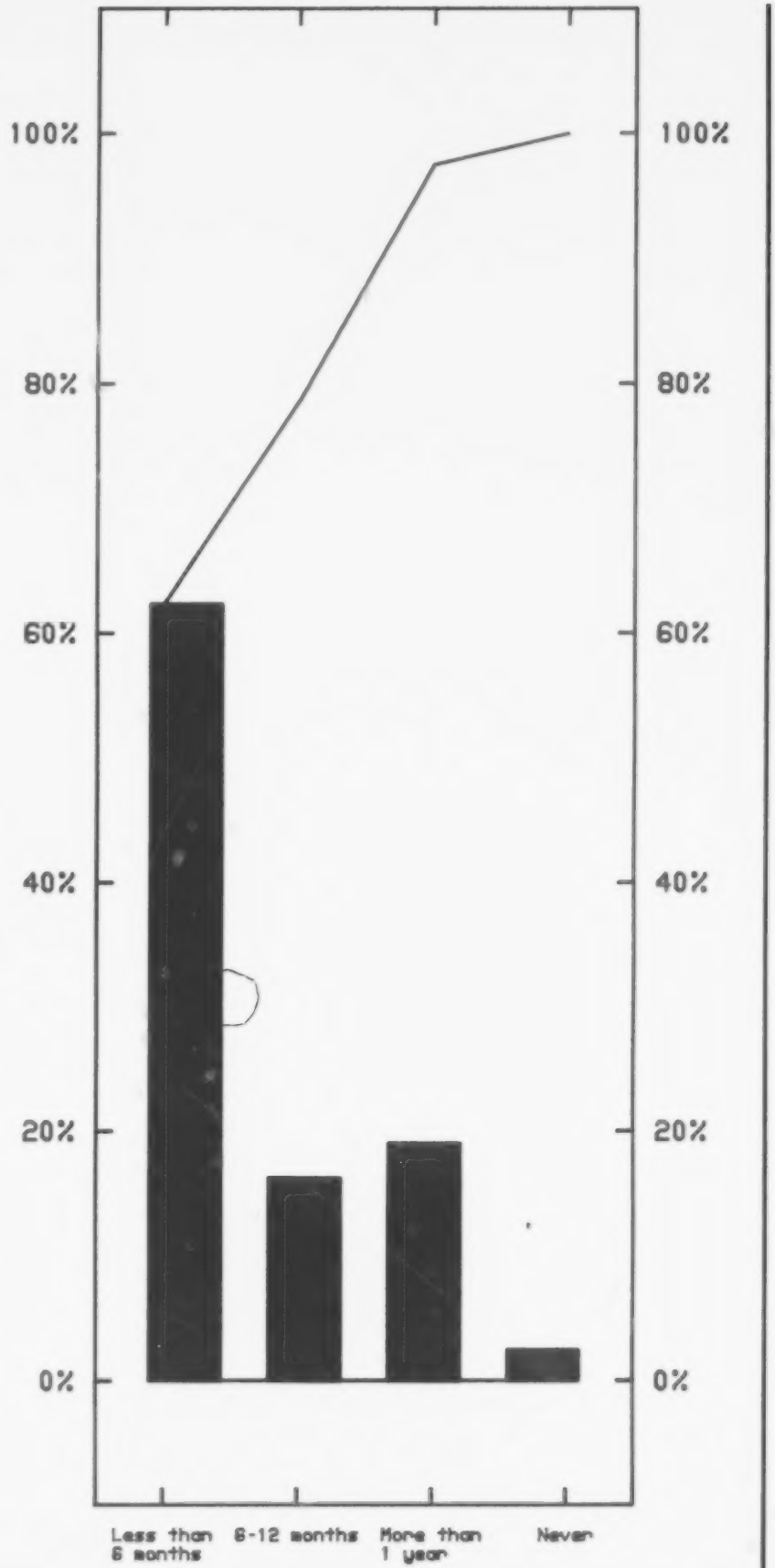
Losing time from work and long office waits were among other reasons for being dissatisfied with health care.



5.5

Preventive Care: Time and Cumulative Time Since Last Blood Pressure Check

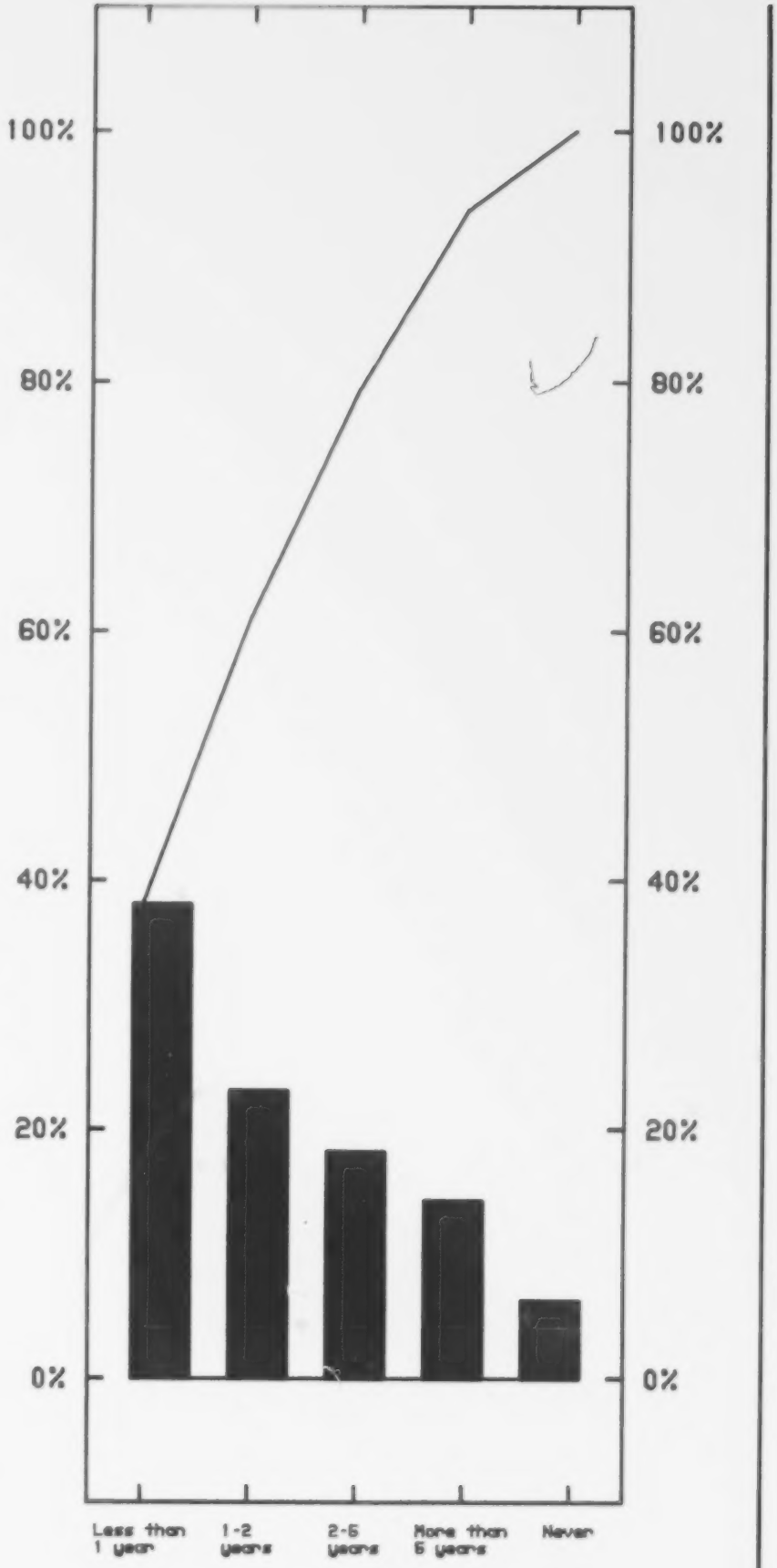
Nineteen percent of respondents had not had a blood pressure check for over a year, and 2.5% never had their blood pressure taken.



5.6

Preventive Care: Time and Cumulative Time Since Last Physical Examination

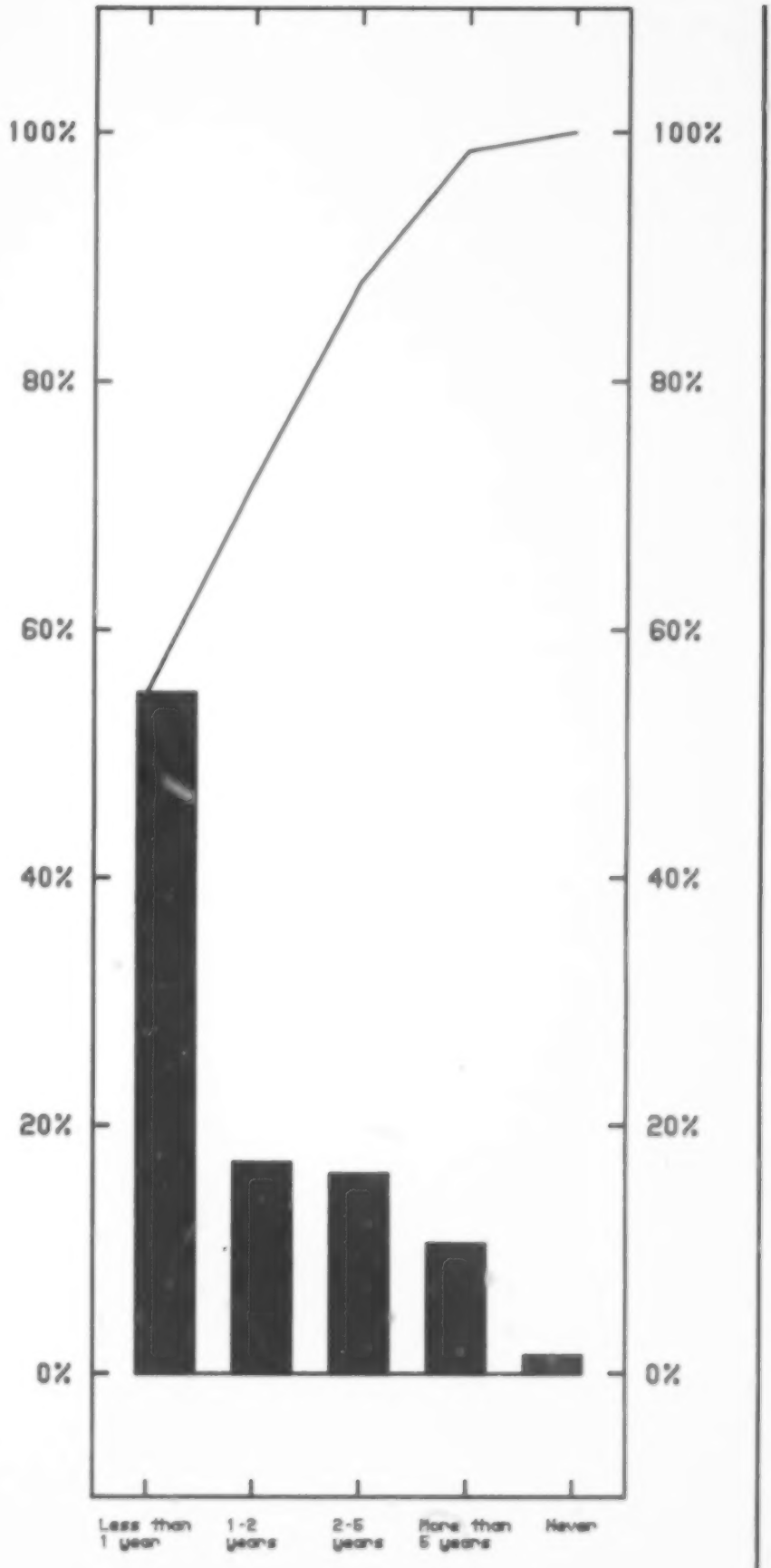
Six percent of the respondents had never had a routine physical examination, and 32% had a physical examination five or more years ago.



5.7

Preventive Care: Time and Cumulative Time Since Last Dental Examination

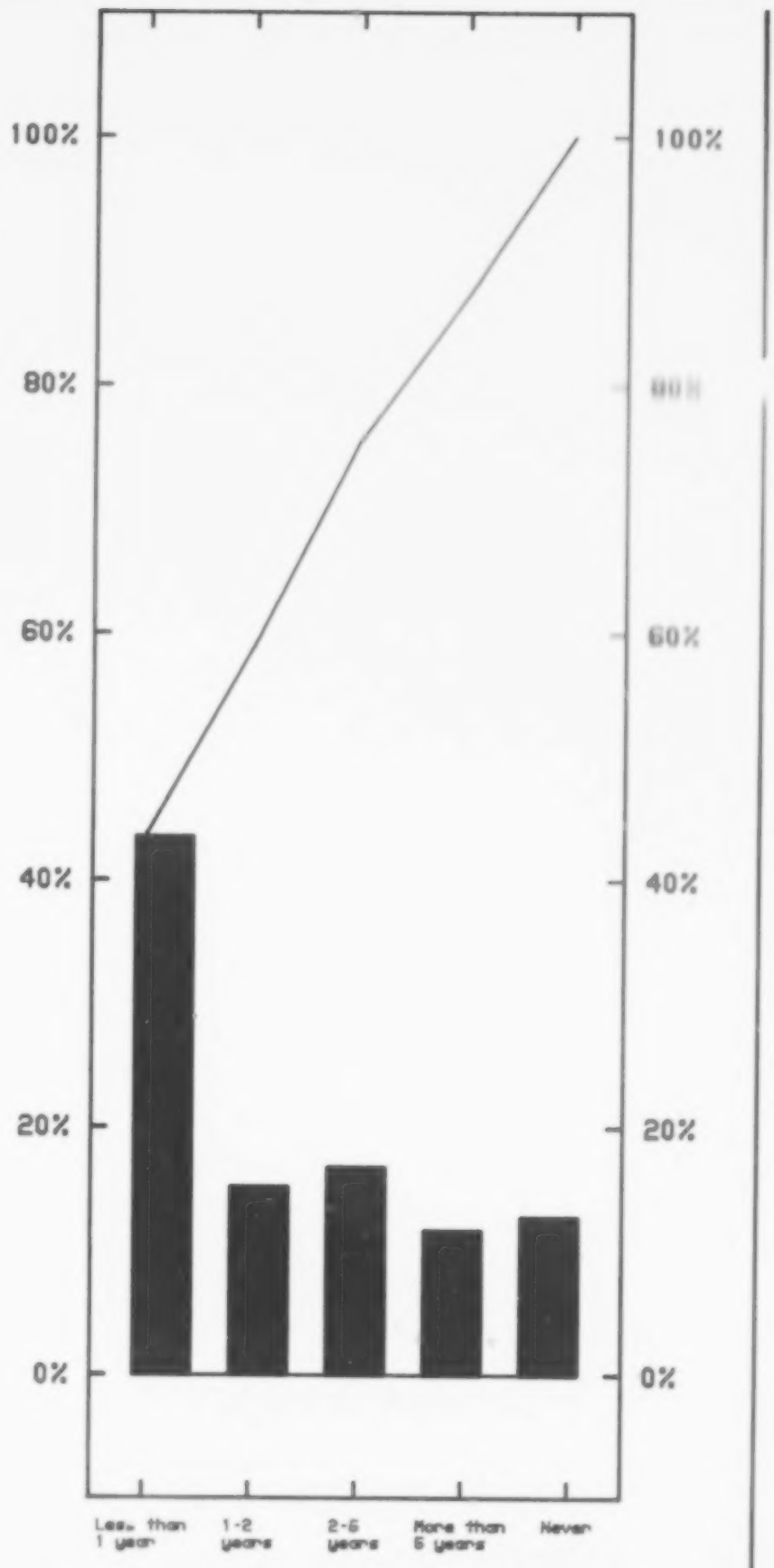
One and one-half percent of the respondents had never seen a dentist, and 10½% last visited a dentist more than five years ago.



5.8

Preventive Care: Time and Cumulative Time Since Last Cleaning of Teeth

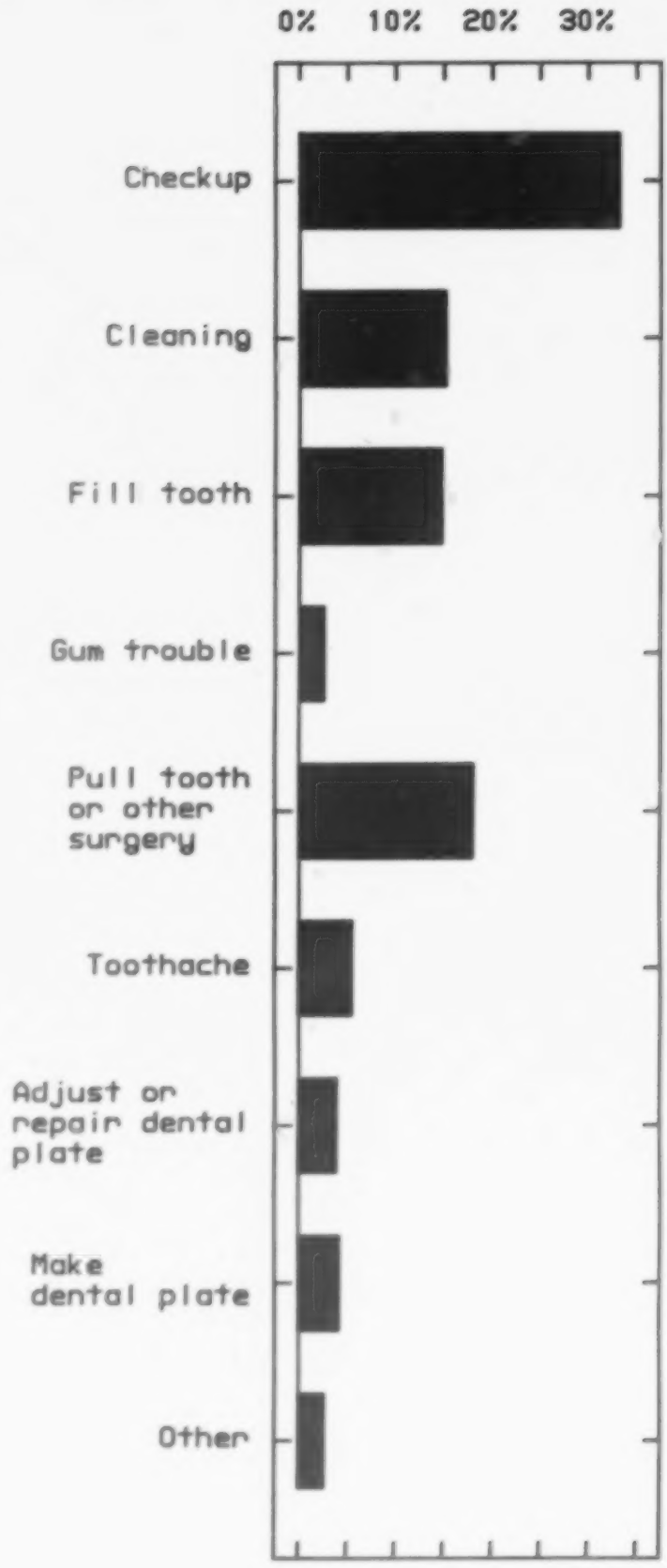
Over 12% of the respondents had never had their teeth cleaned and almost 12% had not had their teeth cleaned for more than five years.



5.9

Reason for Last Visit to Dentist

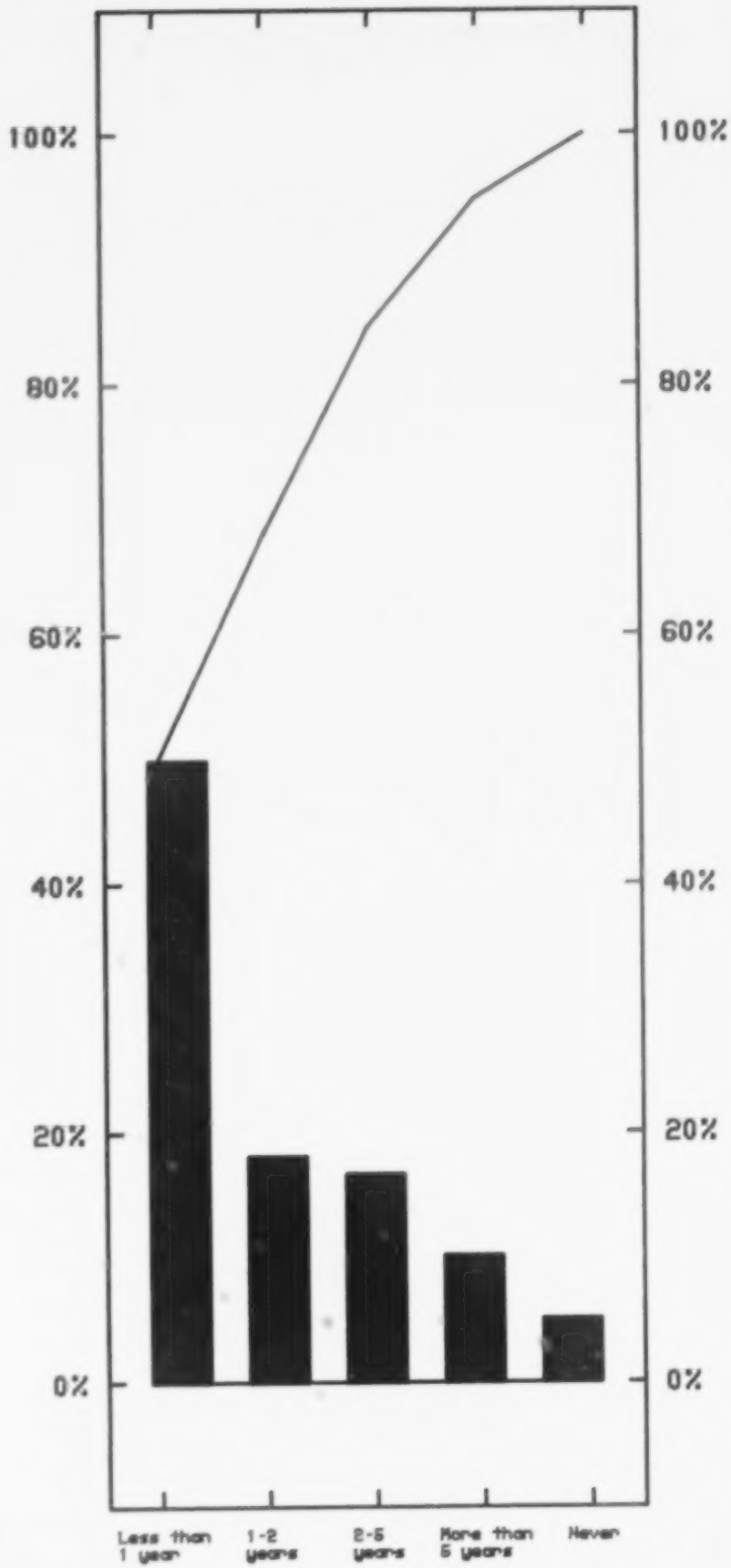
The largest percent of patients last visited a dentist for routine care.



5.10

Preventive Care: Time and Cumulative Time Since Last Vision Screening

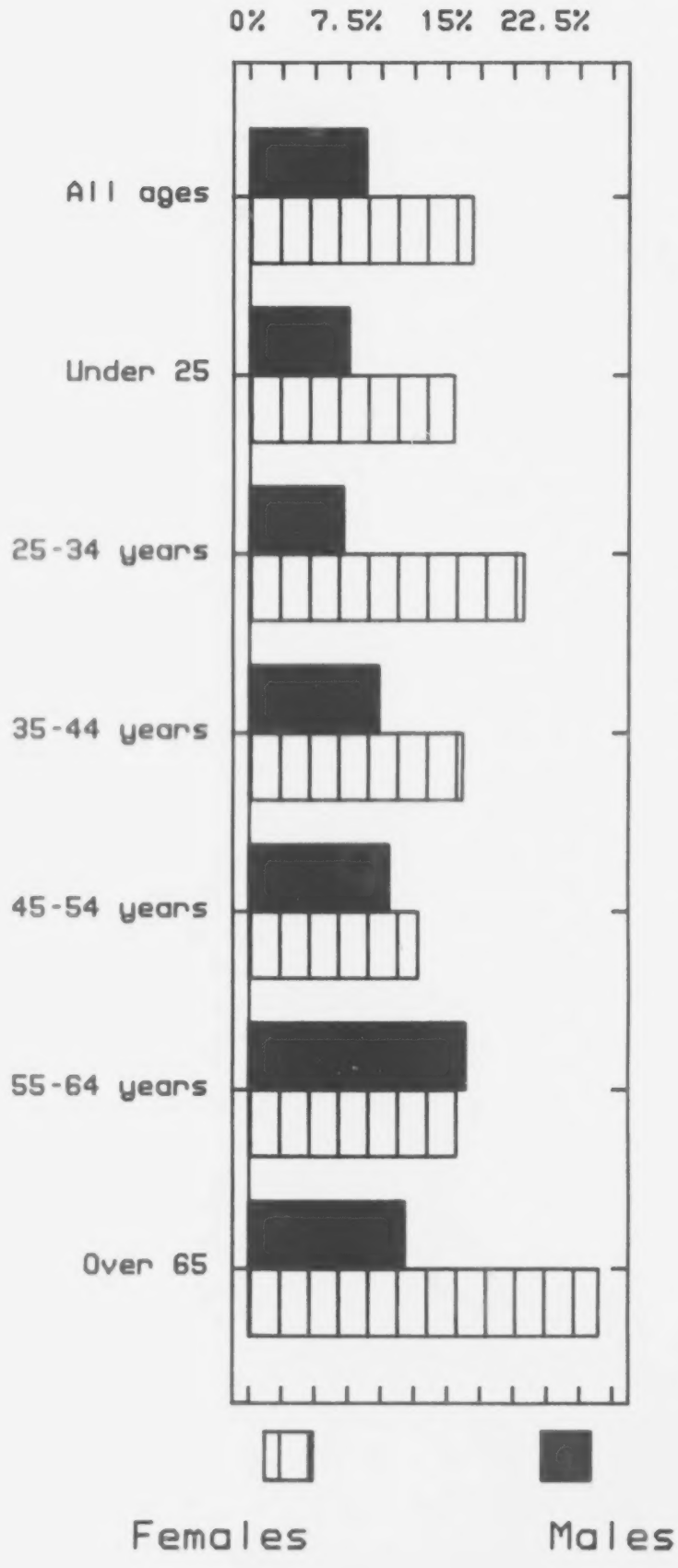
Fifty percent had had their eyes examined less than one year ago, however over 5% had never had an eye examination.



5.11

Age-Sex Specific Rates for Stay in Hospital in Last 12 Months

Women were more likely than men to have spent at least one night in a hospital during the twelve months prior to the interview except in the 55-64 years category.



CHAPTER 6

Financial Issues

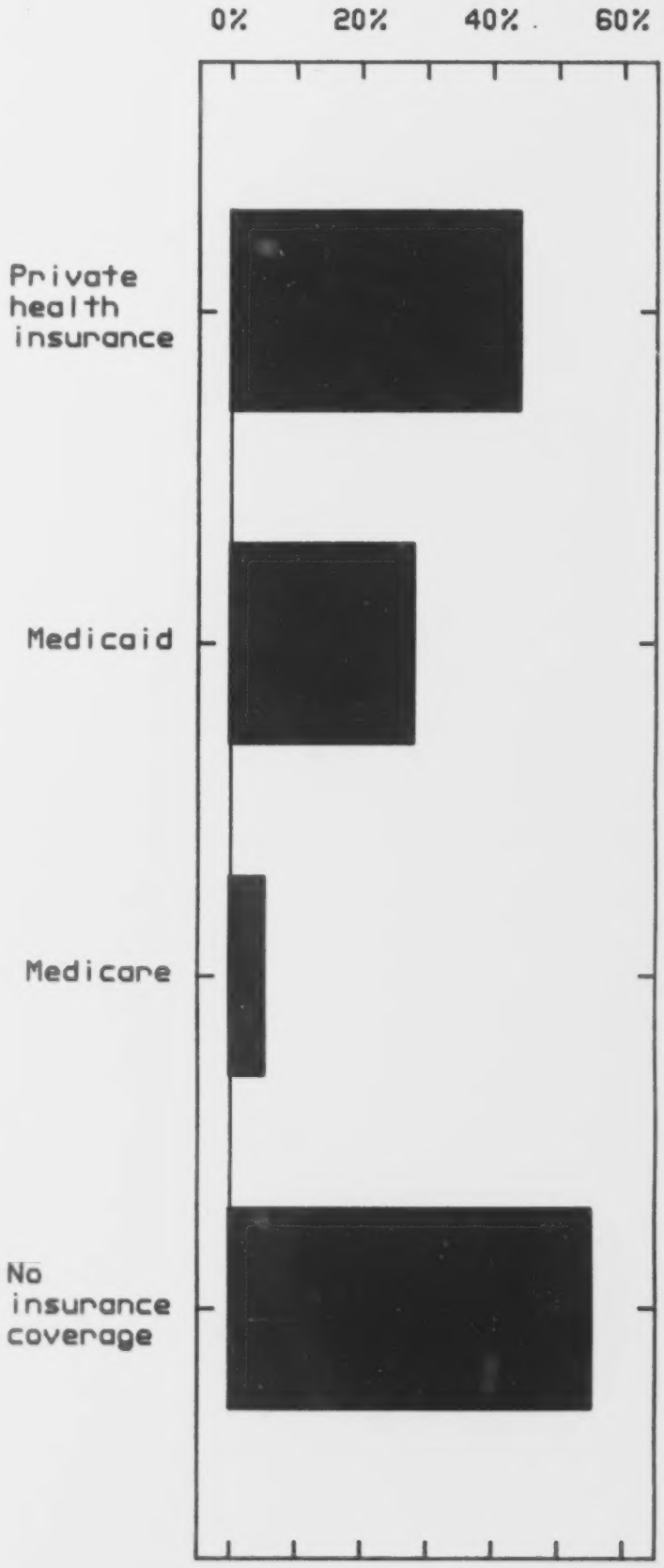
Socioeconomic factors had considerable influence upon whether a respondent received medical care when needed. This section indicates that approximately 55% of respondents had no type of insurance coverage. Equally important is the finding that over one half of respondents "not covered by insurance" did not believe they could afford to purchase health insurance.

Several charts in this document reflect the impact of poverty upon the Puerto Rican family. Nowhere is it demonstrated more poignantly than in this section. A relatively small percentage of respondents were covered by medicaid or other welfare medical benefits. Financial changes underway in America in both hospital and physician reimbursement will require further study of both access and quality of medical care for the Puerto Rican.

6.1

Private Health Insurance, Medicaid and Medicare Coverage

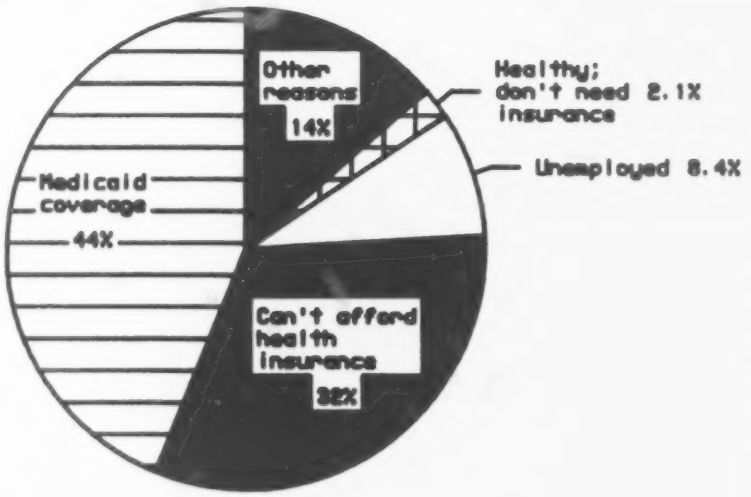
Fourty-four percent of respondents had some form of private health insurance, however *55% had no insurance coverage.*



6.2

Why Respondent was not covered by Private Health Insurance

Of those persons without private insurance coverage, 44% had medicaid coverage and 32% could not afford health insurance.



Subject Index

	Pages
Anemia	42
Birth Place	14, 27, 30
Blood Pressure	34, 35, 36
Bronchitis	46
Cataracts	58
Chest Pain	43, 44
Cholesterol	67
Cirrhosis	53
Diabetes	38, 39, 40
Dentist	82, 83, 84
Education	19
Emphysema	45
Eye Trauma	60
Family Size	23
Fertility	73
Glaucoma	57
Goiter	61
Gums	33
Health Care Access	78, 79
Health Care Utilization	76, 77, 86
Health Insurance	31, 88, 89
Health Status	28, 29, 30
Hearing	69
Heart Attack	51
Heart Failure	50
Heart Murmur	49
Hepatitis	54
Hypertension	34, 35, 36, 37, 38
Income	21, 22
Kidney Disease	52
Labor	20
Menarche	72
Pap Smear	74
Population	18, 23, 24
Preventive Care	80, 81, 82, 83
Poverty Index	22, 31
Rheumatic Heart Disease	47, 48
Rheumatic Fever	47, 48
Smoking	63, 64, 65, 66
Strabismus	59
Stroke	56
Teeth	33, 83
Thyroid	62
Tobacco	63, 64, 65, 66

Subject Index
Continued

Tuberculosis 41
Vision 68, 85
Weight 32
Yellow Jaundice 55

Acknowledgement

The authors are indebted to Christina Weiss for the preparation of this book.

89